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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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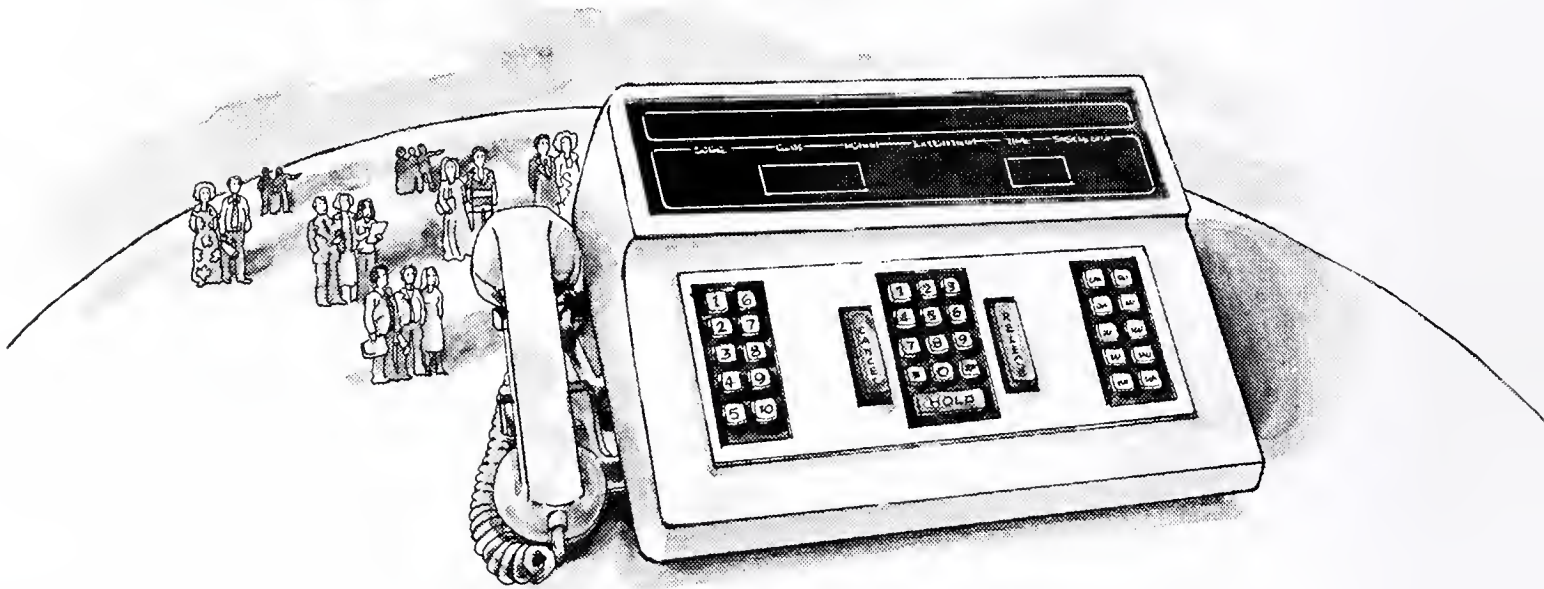
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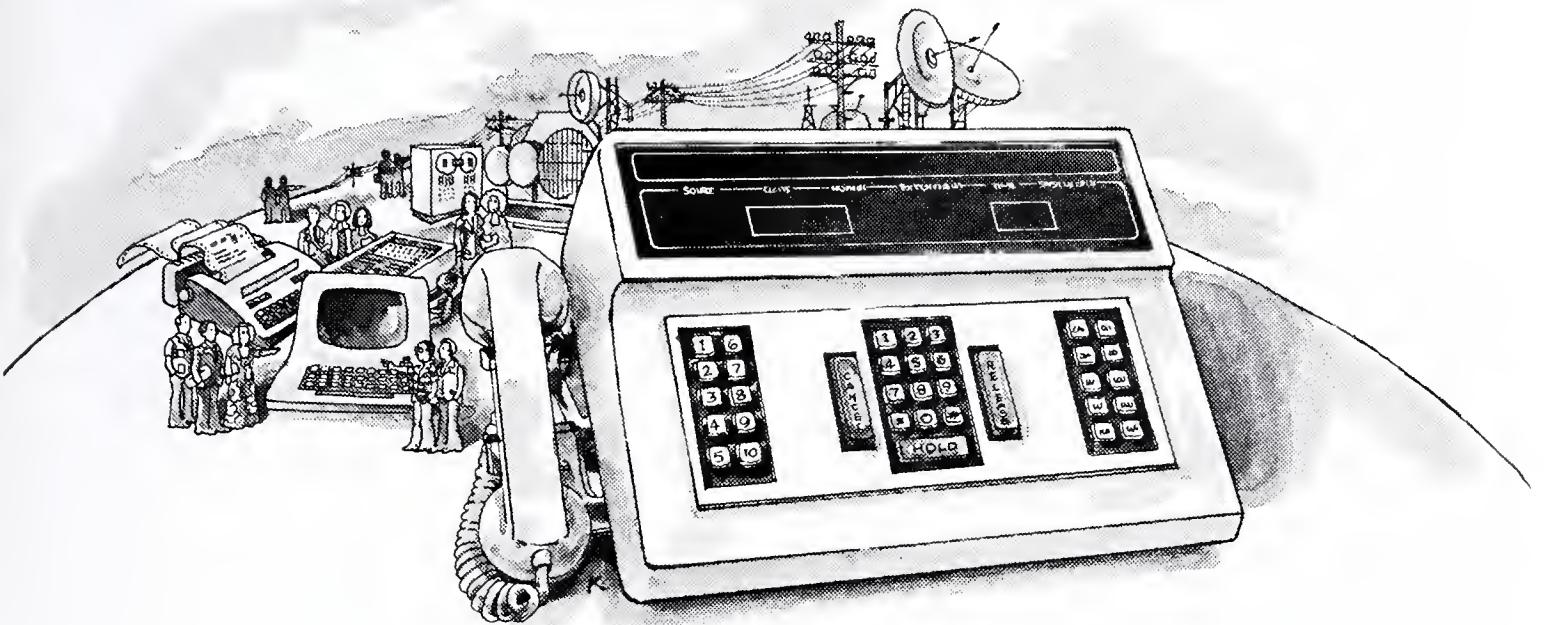
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A Good Neighbor Policy: Controlled Smoking Areas and Health Department Attitudes

ROBERT C. MARVIT, M.D., M.Sc.,* KLEONA B. RIGNEY, M.D., M.P.H.***, and
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● *A need to regulate smoking in public areas has been mandated by public concern. To determine the most effective policy, 3,000 Health Department employees were surveyed statewide. Results overwhelmingly support some form of restriction, regardless of the respondents' own smoking behavior. About 25 percent of the smokers said they would attend "quit smoking" clinics, if offered at their work site. A policy to create controlled smoking areas in the Hawaii State Health Department system will be based on this survey. The active participation of employees to control smoking may prove the most effective means of reducing tobacco consumption. A follow-up survey is planned one year hence to determine the effectiveness of the policy and the attitude and behavior of the workers.*

The Surgeon General declared cigarette smoking to be harmful to the smoker's health in 1964.¹ Since then, smoking behavior as well as the effects of cigarette smoke on non-smokers have often made the news.² The Federal Government, through the Office of the Surgeon General, has mounted a campaign to encourage the health professionals not only to give up smoking themselves but to persuade their patients and the general public to give up the habit also.³

Studies conducted since the initial Surgeon General's report have indicated that health professionals continue to lead Americans in cutting back on smoking, stopping altogether, and doing something to get others to quit.^{4,5} "A Survey of Health Professionals; Smoking and Health, 1975," was conducted by the National Clearinghouse for Smoking and Health in collaboration

with the National Cancer Institute. This report, which included a random sample of about 20,000 health professionals in the United States, examined smoking behavior, perception of responsibility and concerns about the relationship between cigarette smoking and selected diseases. Results indicated that the health care professionals were generally aware of the harmful effects of cigarette smoking and were increasingly willing to accept the responsibility for helping their clientele and the public to quit smoking.⁶

The Department of Health of the State of Hawaii is the second largest department in the state government in terms of personnel and budget. It has a legal mandate to not only assist in the management and treatment of disease on a statewide basis, but also to promote health and positive health behaviors.

Legislative approaches to restrict smoking in public areas have met with varying responses.⁷ To provide the Department of Health with a sound basis for the establishment of policies to control smoking, over 3,000 departmental employees were queried. It was assumed that the concerns and attitudes of the participants would clearly determine the effectiveness of a smoking control policy.⁸

Since employees of the Department of Health represent a cross section of a significant at-risk group of the community, it was also assumed that the attitudes of the employees represented the attitudes of the community at large. With these factors in mind, it was considered appropriate that a model policy for controlled smoking areas in the work environments of the State Health Department be developed and implemented, based on employee attitudes. The effectiveness of such a policy could serve as a basis for proposed legislation to be implemented on a statewide basis.

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Methods

A single page questionnaire (Figure 1.) was developed to cover 3 salient areas. The first area related to past and present smoking behaviors. The second related to the attitudes regarding restricting areas for smokers and non-smokers.

The third was to indicate an interest in participating in a "quit smoking" clinic. The questionnaire had a limited description of the respondent, including age, sex, and work site. The questionnaires were filled in anonymously and returned to the department's central office.

FIG. 1.—Questionnaire on Smoking

This questionnaire is to determine the smoking habits of employees of the Health Department and their feelings regarding restricting certain areas to smoking. Please complete this form and return to Chronic Disease Branch by October 20, 1978.

Even if you do not smoke, please complete this questionnaire.

- Sex
 - 1) M _____
 - 2) F _____
- Age
 - 1) Under 25 _____
 - 2) 25-34 _____
 - 3) 34-44 _____
 - 4) 45-54 _____
 - 5) 55 & Over _____
- Work Site
(Building where you usually work)

1) Kinau Hale _____	15) Maluhia _____
2) Lanakila H.C. _____	16) State Hosp _____
3) Kapahulu H.C. _____	17) Waimano _____
4) Windward H.C. _____	18) Maui-DHO _____
5) Leeward H.C. _____	19) Maui Hosps _____
6) Waipahu H.C. _____	20) Maui-Other _____
7) Waimanalo _____	21) Kauai-DHO _____
8) Nanakuli _____	22) Kauai Hosps _____
9) Vector Con _____	23) Kauai-Other _____
10) Diamond Head _____	24) Hawaii-DHO _____
11) Other M.H. Cls _____	25) Hawaii Hosps _____
12) Child Dev. Cls _____	26) Hawaii-Other _____
13) Leahi Hosp _____	27) Other _____
14) Wilcox Bldg _____	(Specify) _____
- Do you smoke *any* cigarettes at the present time?
 - 1) Yes _____
 - 2) No _____
- How many cigarettes do you smoke a day, on the average?
 - 1) Less than a pack _____
 - 2) One pack or more _____
 - 3) 1-2 packs _____
 - 4) 2 or more packs _____
- Do you smoke cigars regularly?
 - 1) Yes _____
 - 2) No _____
- Do you smoke a pipe regularly?
 - 1) Yes _____
 - 2) No _____
- If you are an ex-smoker, what influenced you to stop?
(Check as many as applicable)

1) Family pressure _____	5) Media Pressure _____
2) Doctor's advice _____	6) Other (Specify) _____
3) Expense _____	_____
4) Fear of health consequences _____	_____

Because tobacco has been proven to be not only discomforting to many, but also a potential health hazard to some people, we would appreciate learning your feelings on this subject by your answering the following questions:

- I am in favor of having no-smoking sections in common work areas.
 - 1) Yes _____
 - 2) No _____
- I am in favor of having no-smoking sections or tables in our dining rooms or cafeterias.
 - 1) Yes _____
 - 2) No _____
- I think smoking should be banned throughout the Health Department buildings.
 - 1) Yes _____
 - 2) No _____
- I think smoking should be banned in all Health Department Clinics.
 - 1) Yes _____
 - 2) No _____
- I think smoking should be banned in all Health Department waiting rooms.
 - 1) Yes _____
 - 2) No _____
- Comments _____

Would you be interested in attending a "Quit Smoking" clinic if offered at your work site, either free, or at nominal cost (not over \$10)?

- 1) Yes _____
- 2) No _____

If interested, please print your name, work site, and telephone number.

Name _____

Work Site _____

Business Telephone No. _____

Results

A total of 3,500 questionnaires were distributed to all islands and 2,614 usable returns were received. The return rate on the questionnaires was 75%, 27% from men and 73% from women. Of the total number of respondents, 748 (28.6%) were smokers. Adjusting for sex differences, 37% of the male employees were smokers and 25% of the female employees were smokers. In 1968, a similar survey was done on a smaller scale, with 413 forms and 307 returns. At that time, 25.7% of the respondents were smokers, 33% of the men 22% of the women.

The age and sex distribution is shown in Table 1. Table 2 shows smoking patterns by sex. Figure 2 shows attitudes toward restrictions, based on habit subgroups.

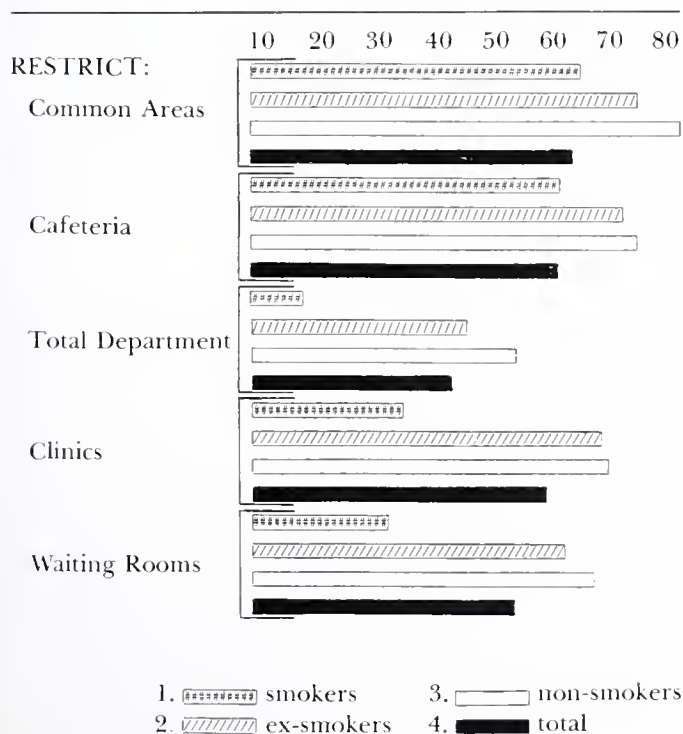
TABLE 1.—Age and Sex Distribution of Sample

	MALES	FEMALES	TOTAL
Age Less Than 25	1.36%	4.54%	5.90%
25-34	8.84%	18.65%	27.49%
35-44	6.29%	20.76%	27.05%
45-54	7.15%	20.49%	27.64%
More Than 55	3.79%	8.13%	11.92%
% For Sample Total	27.43%	72.57%	100%

TABLE 2.—Smoking Patterns By Sex

	MALE	FEMALE	TOTAL
Smokers	10.15%	18.30%	28.45%
Ex-Smokers	6.98%	12.43%	19.41%
Non-Smokers	10.27%	41.87%	52.14%
% Total Sample	27.4 %	72.6 %	100%

FIG. 2—Restriction Attitude by Habit, % Yes Response



Attitudes Regarding Restriction

Of the respondents, 77% favored no-smoking sections in common work areas (65.6% of the smoker respondents). No-smoking sections or tables in dining rooms were favored by 72% (61.5% of the smokers). A total of 44% favored banning smoking throughout the Department of Health buildings statewide (17.8% smokers). About 60% favored banning smoking in the Department of Health clinics where health care delivery is rendered (37.6% smokers); 57% favored banning smoking in the Department of Health waiting rooms (57% smokers).

Smoking Habits

Of the 556 respondents who declared themselves to be ex-smokers, 56% quit for fear of health consequences, 13% on their physicians' advice, 16% because of family pressure, and only 5.6% because of media pressure.

Of respondents who declared themselves to be smokers, representing 25% of all smokers, 152 indicated a desire to attend a quit smoking clinic if offered at their work site.

A total of 360 respondents made comments on the open-ended section of the questionnaire. About 10% stated that they favored restrictions because the State Department of Health should not condone smoking, should set an example to others, and should "practice what we preach." Some comments related to the difficulties of enforcement and concerns about the discomfort and health hazards of exposure to tobacco smoke. A number pointed out the issue of smokers' and non-smokers' rights, the need to designate smoking areas rather than outright banning, and the difficulties that air conditioning with its recirculation presented in public buildings. Only 1% of the open ended comments were pro smoking; these stated it would be cruel and unusual punishment for people to be deprived of their habit. A small number of anti-government regulation comments regarding personal liberty and the invasion of privacy were made, but represented less than 1% of the comments.

Discussion

This study represents the first statewide Health Department survey of both smoking behavior and smoking control attitudes. This study was conducted and completed prior to the release of the new report on smoking.⁹ Nevertheless, it can be seen from the results that a significant number of both smokers and non-smokers are in favor of restricting or controlling the areas for smoking.

The relative percentage of smokers in this State Health Department system is somewhat higher than might be expected in a health agency.¹⁰ Nevertheless, the number of ex-smokers and the number of smokers who would

be willing to participate in a quit smoking clinic is encouraging. The large return on this number of questionnaires suggests that the concern and interest in the issues surrounding smoking is significant.¹¹

The Department of Health is made up of a wide range of facilities, which includes total institutionalized care through chronic long-term hospitals to walk-in crisis intervention ambulatory care clinics. The analysis of attitudes based on work site location revealed that, regardless of the setting, restriction of smoking in one manner or another was considered desirable. The more medically oriented the work site, the more restriction was suggested. At the other end of the spectrum, in the administrative areas, where there is less contact with the public, the degree of restrictive attitudes tends to be less. However, in administrative areas where there is a great deal of public contact, the control or restrictive attitudes tend to be higher.

The concern about the health effects of smoking both by smokers and non-smokers is significant. The fact that the media appears to have had so little influence in getting people to stop smoking, except that it might have been a stimulus for people to go to their physicians, is disappointing.¹² Nevertheless, the concerns about health hazards and environmental problems secondary to smoking seems to affect almost all departmental employees.

As a result of this study, a proposed policy for

the Department of Health facilities is being developed.

Conclusions

Attitudes toward smoking are growing increasingly negative, even among smokers. There is a significant awareness of the health hazards of the habit both to the smoker and those within the smokers' environment.¹³ Employees of the Health Department, whether they were smokers or not, often favored regulations controlling smoking. The degree of restriction is dependent upon the individual's work site as well as personal attitude.

The lack of a clearly enunciated and supported policy regarding the restriction of smoking has limited, in some respects, the decline in smoking behavior.

There appears to be a ground swell of intolerance to smoking both nationally and within our own Department. A clear-cut restrictive smoking policy appropriate to the work site, enforceable in part through peer pressure, and the availability of quit smoking clinics within the work sites, should facilitate a reduction in tobacco use and minimize additional hazards to the non-smokers exposed to smoke in their environment.

The Department will be putting forth such a policy, along with recommended legislation. We intend to re-survey the Department employees one year after the implementation of the new rules to determine their effect.

REFERENCES

1. U.S. Department of Health, Education, and Welfare, Public Health Service. *Smoking and Health; Report of the Advisory Committee to the Surgeon General of the Public Health Service*. Washington: U.S. GPO 1964.
2. U.S. Department of Health, Education, and Welfare, Public Health Service. *The Use of Tobacco: Practices, Attitudes, Knowledge, and Beliefs*, U.S. Fall 64 and Spring 66. Washington: U.S. GPO 1969.
3. Warner KE: The Effects of the Anti-Smoking Campaign on Cigarette Consumption. *Am J Public Health*, 67: 645-650, 1977.
4. U.S. Department of Health, Education, and Welfare, Public Health Service. *Adult Use of Tobacco-1970*. Atlanta Center for Disease Control, June 1973.
5. U.S. Department of Health, Education, and Welfare, Public Health Service. *Adult Use of Tobacco-1975*. Atlanta Center for Disease Control, June 1976.
6. Smoking Behavior and Attitudes of Physicians, Dentists, Nurses, and Pharmacists, 1975. *Morbidity and Mortality Weekly Report*, 26: 185, 1977.
7. Shephard RJ; Labarre, R. Attitudes of the Public Towards Cigarette Smoke in Public Places. *Canadian Journal of Public Health*, 69(4): 302-10, July-August 1978.
8. Fisher L: National Smoking Habits and Attitudes, *Am Lung Association, Bulletin* 63(7): 6-9, September 1977.
9. World Health Organization, *Smoking and its Effect on Health: Report of a WHO Expert Committee*. Technical Report Series #568. Geneva: WHO, 1975.
10. Highlights of the Surgeon General's Report on Smoking and Health, 1979, *Morbidity and Mortality Weekly Report*, 28:1, 1979.
11. Kelemen SA: First Experience of the Inside—Hospital Fight Against Smoking Among Patients and Among the Medical and Paramedical Staff. (*Scandinavian Journal of Respiratory Diseases*, Supplement 102): 154-6, 1978.
12. Varipapa RJ, Odeda J: Health Professionals and Smoking. *Journal of the American Pharmaceutical Association*, 17(8):511, August, 1977.
13. Survey Reveals Smoking Habits of Health Professionals, *American Nurse*, 9(6): 3, 28, 15, June 1977.

Urological Injuries in Gynecological Surgery*

KUNIO MIYAZAWA, M.D., *Honolulu*

• *Injuries to the bladder and ureter, caused by gynecologic procedures, are among the most distressing problems for gynecologists.*

With a view to minimizing this complication, a study was undertaken to review and analyze accidental urological injuries during the course of non-radical major gynecologic surgery performed on a busy teaching gynecology service.

The incidence of urological injury occurred in 0.4% of major gynecologic procedures. The most common injury was bladder laceration, occurring during attempts to enter the anterior peritoneal fold at the time of "easy" vaginal hysterectomy. Immediate recognition and proper expert treatment on the operating table is absolutely essential.

Despite various major advances made in the past 30 years in surgical equipment, anesthesia techniques, pre- and post-operative care and infection control, urological injury in gynecologic surgical procedures remains the most common hazard of gynecologic surgery. In view of recent emphasis on malpractice legal action, it is extremely important not only to understand but also to minimize various urological injuries encountered in gynecologic surgery.

Materials and Methods

A total of 5,517 non-radical major gynecologic procedures were performed at Tripler Army Medical Center, Honolulu, Hawaii, over a 5-year period, January 1, 1973 to December 31, 1977. Retrospective clinical re-

search was performed on all urological injuries encountered on these patients. Major gynecologic procedures were usually performed by a resident member, assisted or supervised by a staff member. When any gynecological major case became extremely difficult and complicated, the staff member took over the operative procedure or a urology consultant was called to assist the gynecology resident and staff member. Such a case was defined as a "difficult" case. Conversely, a case performed chiefly by the resident within a reasonable operating time was defined as an "easy" case. Each urological injury resulting directly from a gynecological procedure was studied with regard to such factors as age, race, parity, weight, past obstetrical and gynecological procedures, pre-operative diagnosis, level of responsible surgeon, type of urological injury, time of discovery, post-operative complication, and final outcome.

Results

Out of the 5,517 major gynecologic procedures, there was a total of 25 urological injuries directly related to these gynecological procedures during the 5-year period. This is an incidence of 0.4% of major gynecological surgery. The age of the injured group ranged from 23 years to 61 years, with an average age of 34 years. The white race was predominant (80%). The average parity was 2.5. The average body weight was 135 lbs.

The most common injury was found to be perforation of bladder, in 21 cases (84%). Bladder laceration at the time of vaginal hysterectomy was highest in incidence, 13 cases (1.3%) of 1,007 vaginal hysterectomies. On the other hand, in a total of 1,029 abdominal hysterectomies, the incidence of bladder laceration was low, 4 cases (0.38%). Bladder perforations most frequently occurred during entry to the anterior cul-de-sac

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*Presented at the 17 Annual Meeting of the Armed Forces District of the American College of Obstetricians & Gynecologists and the 27 Annual Meeting of the Armed Forces Seminar on Obstetrics & Gynecology, Washington, D.C., October 15-20, 1978.

The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.

and ranged in size from 1 cm. to 6 cm. Most of the vaginal hysterectomies involving urinary tract injury were performed for elective sterilization; among 15 cases, 11 were elective sterilization (73.3%). None of these cases met the criteria for "difficult."

On the other hand, all of the urinary tract injuries associated with major abdominal procedures arose from "difficult" cases, a total of 10. All 4 cases of bladder injury associated with total abdominal hysterectomy had past history of cesarean section. Four other cases of bladder injury encountered with abdominal major procedures had operative diagnosis of pelvic adhesions due to previous pelvic surgery (cesarean section, cystectomy, and vaginal hysterectomy, respectively) and advanced carcinoma.

Ureteral injuries were found to be rather rare, 4 cases (0.07%) out of the total major gynecological procedures. All ureteral injuries were found at the distal one-third of the ureter and arose from 2 cases of vaginal hysterectomy for elective sterilization and 2 cases of major abdominal surgery.

Injury by an actual operating surgeon was highest among senior residents (14 cases), second-year residents (6 cases), first-year residents (4 cases), and staff members (1 case). This distribution grossly parallels the actual involvement of resident and staff members in major gynecological procedures as the operating surgeon.

Review of the annual number of major gynecological procedures and urological injuries for the 5-year period is shown on the following Table.

Annual Number of Major Gynecological Procedures and Urological Injuries

	GYNECOLOGICAL PROCEDURES	UROLOGICAL INJURIES
1973	1,014	4
1974	1,157	5
1975	1,365	11
1976	1,104	2
1977	877	3

Most injuries were discovered on the operating table (21 cases, 84%). One case was discovered during the immediate post-operative period, another case on the 4th post-operative day, and 2 cases on the 8th post-operative day. The delay in discovery in the latter cases brought about adynamic ileus and vesicovaginal fistula, respectively. The latter was treated subsequently by surgical repair.

Post-operative hospital stay for the injured patients ranged from 6 to 17 days, with an average stay of 10 days. Final outcome of the 25 injured patients was found satisfactory. All pa-

tients except one received prophylactic antibiotic treatment.

Discussion and Conclusion

It is reported that the incidence of urinary tract injury in non-radical gynecological surgery varies from 0.2 to 2.5%.¹ Although this present study does not include a long-term follow-up because of a transient patient population, the incidence of 0.4% of major gynecological procedures seems acceptable. In spite of the fact that various physicians acted as the operating surgeon, utilizing various techniques, bladder injury was highest in incidence, 1.3%, in vaginal hysterectomy, contrasted to 0.38% in abdominal hysterectomy. This study confirmed a previous report² that bladder perforation was most frequently made during the attempt at entry into the vesico-uterine fold, and also revealed that this is especially true in rather "easy" vaginal hysterectomy.

Contrasted to bladder injury, ureteral injury was rare, with an incidence of 0.07% of all major gynecological procedures. The incidence of ureteral injury in pelvic surgery is said to vary tremendously from series to series,³ but our incidence is lower than the general incidence, between 0.5 to 1.0% of all major pelvic surgery, which is stated by Mattingly.⁴ Although no attempt was made to obtain routine intravenous pyelogram pre- or post-operatively on the study group, intraoperative direct visualization or palpation of the ureters had been routinely employed by the operating team whenever possible.

This study also agreed with a previous report⁵ in 1949 that injuries of the ureter were more serious than those of the bladder and all of these were found in the distal one-third of the ureter. In summary, this study indicates the following conclusions:

1. A relatively high incidence of bladder perforation occurs in "easy" vaginal hysterectomy, especially at the time of entry to the anterior peritoneal fold.
2. Urological injury arises from "difficult" abdominal cases, especially those with previous cesarean section.
3. The level of the operator's training does not appear to be directly related to injury; rather, it seems appropriate to state that, when there are more operative procedures, there are more complications.
4. Delayed discovery of urological injury has a potential danger of prolonged incapacitation, even if properly treated; but immediate discovery on the operating table together with proper expert treatment will not even prolong hospitalization.

REFERENCES

1. Buchsbaum HJ, Schmidt JD: Gynecologic and Obstetric Urology. Philadelphia, WB Saunders Company, 1978, p 90.

2. Pratt JH: Common Complications of Vaginal Hysterectomy: Thoughts Regarding Their Prevention and Management. *Clin Obstet Gynecol* 19:650, 1976.

3. Corlett RC: Surgical Injury to the Lower Urinary Tract. *Current Problems in Obstet Gynecol* 2:15, 1978.

4. Mattingly RF: TeLinde's Operative Gynecology. Philadelphia, JB Lippincott Company, 1977, p 293.

5. Holloway HJ: Injury to the Urinary Tract as a Complication of Gynecological Surgery. *Am J Obstet Gynecol* 60:30-40, 1949.

Mushroom Poisoning by *Chlorophyllum Molybdites* in Hawaii

C. W. SMITH,* *Honolulu*

During the past 3 years I have had a number of calls from physicians requesting assistance in suspected cases of mushroom poisoning. In well over 90 percent of these cases, the toxic mushroom has been *Chlorophyllum molybdites* (other names used in past texts and literature include *Chlorophyllum morgani* and *Lepiota morgani*). Incidentally, I have also confirmed one case of poisoning in a Great Dane. This paper provides descriptions of the fungus, emphasizing obvious characters to be used for quick identification, as well as typical symptoms, general treatment, and a procedure for species verification from vomitus or stool samples.

Most of the people affected fall into 2 groups: recent immigrants from the mainland, and young people trying to enhance the effect of, or mistaking the identity of, our local psychotropic species *Copelandia cyanescens* (also known as *Panaeolus cyanescens*). The first group mistakes *C. molybdites* for other superficially similar, edible species, for example *Lepiota procera*, which does not grow in Hawaii. The second group will obviously try anything. They have frequently recently taken alcohol, which tends to aggravate the problem.

Another problem associated with this mushroom is its unpredictable toxicity in various people or on one person at different times. Some people are affected, others are not. Since the unaffected people cannot believe the mushroom to have been at fault, sufferers tend to look for other reasons for their distress, which can hinder diagnosis. To further confuse the situation, some people may be affected by the toxicity after several previous meals without effect.

Symptoms

Symptoms usually appear between 30 minutes to 2 hours after ingestion, though in some mild cases may not appear for up to 4 hours. Nausea commences soon followed by stomach cramps, vomiting, and diarrhea. The vomiting and diarrhea can be violent, and if so, bloody diarrhea is not uncommon. Other symptoms include dizziness, faintness, tingling sensations, and general weakness. Dilation of the pupils, photophobia, or a sensation of bright light are not uncommon.

In severe cases the symptoms may last long enough, and dehydration become severe enough, to require hospitalization. In cases requiring hospitalization, hepatic and renal parameters should be followed, in case the mushroom may have been contaminated with other species.

Treatment

All of the ingested mushroom should be removed from the stomach, if possible. When the poisoning has not already caused vomiting, an emetic is indicated. The vomitus should be saved for spore identification, if the mushroom has not been positively identified from macroscopic material that the patient or friends have brought in.

After the gastrointestinal tract is emptied, antispasmodics or antiemetics as well as analgesics are recommended. Sedatives may be useful when anxiety or hysteria are present.

There is no antidote to the toxic agent, an unidentified protein. If the patient is kept comfortable, the symptoms should subside within 24 hours and be gone after 48 hours, except in cases of severe poisoning or extreme sensitivity.

*Associate Professor of Botany, Department of Botany, University of Hawaii at Manoa.

Accepted for publication June, 1979.

Description

The mature mushroom is large, the cap being typically from 2.5 to 7 inches diameter. On its upper surface are buff-to-brown flakes over the white flesh. The flakes are typically denser at the center, forming a more or less continuous dark spot. The gills on the lower surface of the cap are close together but not attached to the stalk. They are generally a dull green, at least in part. If the gills of a fresh mushroom are placed on a piece of white paper and covered by a bowl, preventing desiccation, a green spore print will be produced after 2-4 hours. All these structures except the spores will turn brown when old or damaged.

The stalk is long (3-8 inches), robust, and white, with a visible, membranous ring (annulus) around its upper portion. There is no cup-shaped structure (volva) at the base, and the base is not distinctly swollen.

Unfortunately, most people prefer to eat the button stages, which can make it difficult to

identify the mushroom with certainty. However, the following characters will be sufficient to positively identify the species:

1. Button more than one inch diameter, a solid, white, fleshy structure with brown flecks which form a continuous cap on top.
2. Stem robust and fleshy with the base only slightly swollen. No loose cup-shaped structure around the base.

The mushroom will have been eaten raw, or only parboiled; thorough cooking destroys the toxin. It will have been collected from a lawn or other frequently-mown area.

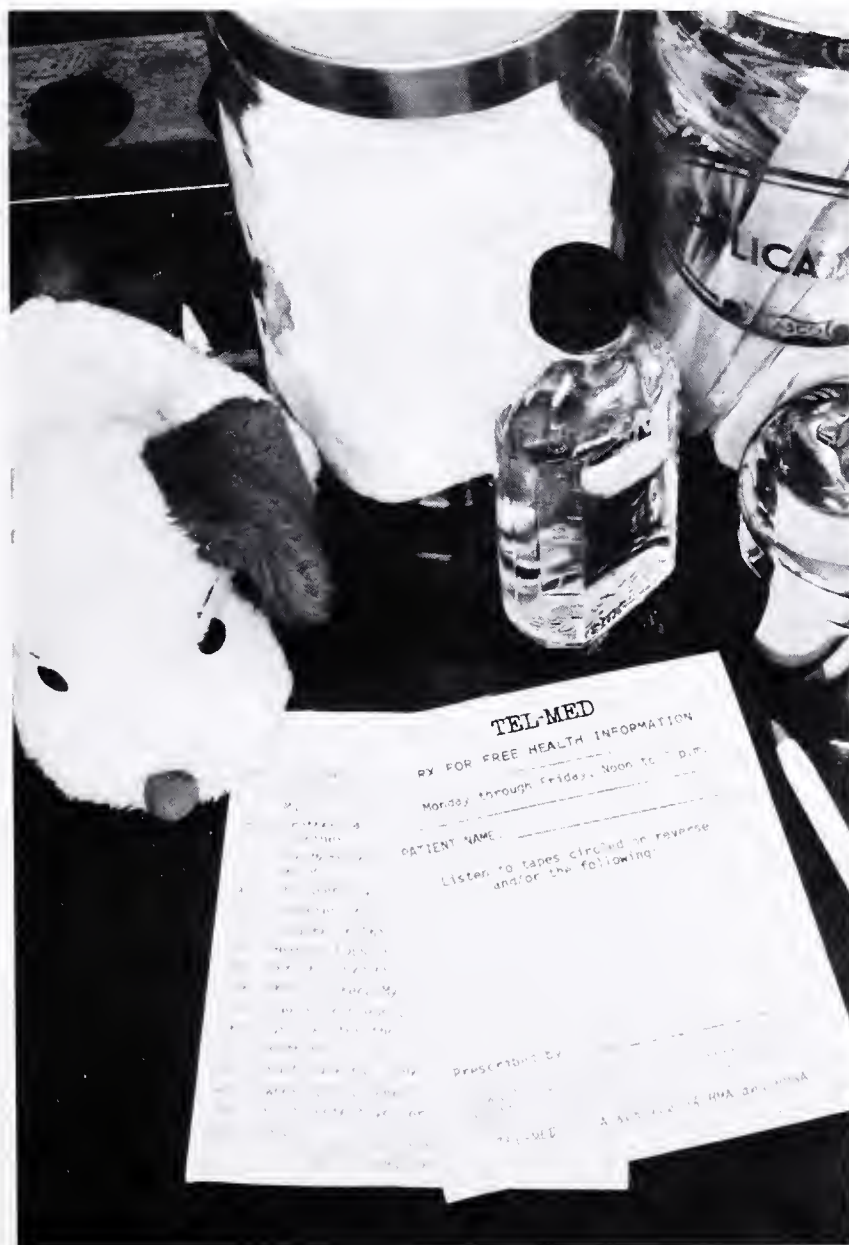
If positive identification is needed, the vomitus or stools can be examined for spores using a simple technique.¹

REFERENCE

1. Eilers FI, Barnard BL: Rapid method for the diagnosis of poisoning caused by the mushroom *Lepiota morgani*. *Am J Clin Pathol* 60: 823, 1973.

Pediatricians:

Write a prescription for information.



Tel-Med prescription slips are a great way to “order” information to the parents of your young patients. They’ll learn the answers to many commonly-asked child care questions like the cause of hearing loss, diabetes, thumb sucking and croup.

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Speak Up!

Item: A breathless Federal Trade Commission (FTC) press release trumpets the agency's victory over the AMA's "unlawful" restrictions on advertising, which were "severely inhibiting competition," resulting in "substantial economic harm" to consumers. Loaded with self-serving puffery, the release clearly suggests that, were it not for FTC heroism, the people would continue to be swindled by conniving doctors.

Item: In a recent local newspaper interview, an attorney said that legal fees of \$100 an hour were quite reasonable when compared with "going to a physician who charges as much as \$400 an hour" (by cramming appointments).

Item: A tearful lens implant patient brings in a terrifying newspaper clipping: the Food and Drug Administration (FDA) has discovered complications with certain intraocular lenses, and will immediately restrict surgeons, inspect factories, and test lenses. With any luck, it seems, the agency may be just in time to protect people from their ophthalmologists before disaster occurs. We reassure our patient that implantation of most of these problem lenses was discontinued two years ago, a fact well known by the FDA. "But why the dramatic headlines?" she said. Why, indeed!

These examples of deprecation of the physician's image by outright falsehood or half-truth and innuendo seem increasingly common. We are variously portrayed as ignorant, or venal, or callous profiteers, to be regarded with suspicion or mistrust if not completely restricted and regulated. We can all see the illogic or the lie, but we can't expect the public, which hears only one side of the story, to ever understand our unspoken viewpoint.

Let's try, in this new year, to take a moment to respond to erroneous or unjust criticism of our profession whenever we encounter it. Granted it takes time to write an editor or a congressman, but unless you speak up, who will speak for you?

Responses need not be elaborate, and shouldn't be vindictive: merely a clear and concise statement of the facts, to set the record straight.

The people want to hear your side of the story. Don't keep it to yourself. Speak up! The truth may keep you free.

Nationalized Nonsense

The Feds are sending money to each state for distribution to needy citizens to help pay their winter fuel bills. Last month, \$3 million of that fuel subsidy in one state went to persons living in foster care facilities or homes for the aged, who have no heating bills. No one's sure why they got the money, but one operator of a home for the mentally handicapped speculated that it might buy a lot of candy and pop.

We are receiving our winter subsidy in Hawaii too, because Washington cannot manage variations in local needs, and politicians and bureaucrats love dramatic national schemes, no matter how mindless.

This flair for drama would organize a national health insurance scheme for us, too, which we need about as much as heating oil. The Hawaii Prepaid Health Care Act created an insurance system which is unique in its nearly universal coverage, comprehensive benefits and low costs. A DHEW Study concluded that our experience could serve as a model for the development of "*a comprehensive national health insurance program.*"

But, why a "program"? Why not simply explain our system to the other states, so they may use it if they choose? Why make anything mandatory or national? And if our system works so well, why penalize Hawaii by involving us in any nationalized nonsense which might not suit our needs?

Very few federal programs are ever run properly; without local medical autonomy, we'll be doomed to waste a lot more than money. Meantime, what do we do with this heating oil?

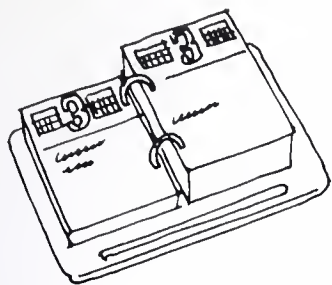
Restraint

In the year which has passed since the lifting of formal restrictions on advertising by physicians, it is gratifying to see the restraint which has prevailed.

Except for a few instances, the classified telephone directory and daily papers have not reflected any rush to promotion or solicitation.

It seems that the opinion of one's peers, and careful consideration of the many costs of advertising, are more effective in discouraging promotional ventures than were any formal restrictions by our organizations. Guess you knew that all along.

JMC



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tuesday, 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.

5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
 - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room II).
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HII Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respiro, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Lectures
2. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
3. G. I. Conf., Third Tuesday, 8:00-9:00 a.m.
4. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Endocrine & Metabolism Conf., First, Second, & Third Wednesdays, 7:30-8:30 a.m.
6. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
7. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
8. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
9. Surgical Conf., First, Second, Third, & Fourth Fridays, 12:45-1:45 p.m.
10. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. First 7:00 a.m.
3. Dept. of Med. Monthly Mtg. Second Tues. ea mnth. 7:30 a.m. Sullivan 4-classroom.

4. Surgical Grnd. Rnds. Fridays (except Fourth), 7:30-8:30 a.m. Sullivan 4-classroom.
5. Surg. Mortality & Morbidity Conf. Fourth Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. Hematology Conf., Third Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. Renal Conf. First Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. Pulmonary Conf. Second and Fourth Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.
10. Endocrinology Conf. last Monday ea. month 12:30-1:30 p.m. UH-4 Classroom.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS

- | | |
|-------------------|--|
| Feb. 10-17, 1980 | Otolaryngology Update, Hilton Hawaiian Village 10-14 & Kona Hilton, 14-17. U of C Dept. of Oto & Sacramento Soc. of Oto. Leslie Bernstein, M.D., D.D.S. P. O. Box 3213, El Macero, CA 95618. |
| Feb. 11, 16, 1980 | Surgical Pathology, Problems In. Kauai Surf, 32 hrs. Cat. 1. Univ. of Chgo. |
| Feb. 16-23, 1980 | Postgraduate Course in Clinical Allergy, Maui Surf, 28 hrs. Cat. 1. J.A. Burns School of Med. |
| Feb. 16-23, 1980 | Dilemmas in Obstetrics, U of Cal. San Fran. Held at Kauai Surf. |
| Feb. 16-23, 1980 | Physicians' Program in Undersea Med., Undersea Medical Society. |
| Feb. 22, 1980 | Symposium on Cisplatinium, Comm. Cancer Control Prog./HMA, 1-5:00 p.m., 3 hrs. Cat. 1. To be held at Mabel Smyth Aud., Honolulu. |
| Feb. 21- | Professional Laboratory Management Insti- |

- 27, 1980 tute, Am College of Pathologists, Sheraton Waikiki & Sheraton Maui.
- Feb. 21-23, 1980 Laryngectomy Rehabilitation Seminar, Ala Moana Hotel-Honolulu. HI Div., Am. Cancer Soc., 200 N. Vineyard, 96817. 17 hrs. Cat. I.
- Feb. 23-Mar. 1, 1980 Intercontinental Conf. on Diagnostic Medicine, Ohio Acad. of Family Prac. Held on Maui.
- Feb. 25-Mar. 1, 1980 Recent Advances In Laboratory Medicine, 32 hrs. Cat. I, Univ. of Chgo. Held at Kauai Surf.
- Feb. 27-Mar. 5, 1980 Advances in Clinical OB/GYN, U of Kansas. Held on Maui.
- Feb. 25-28, 1980 Winter Traveling Med. Ed. Course, Kansas City SW Clinical Soc., Royal Lahaina, Maui.
- Mar. 1-8, 1980 American Urological Association, Western Section, King Kamehameha Hotel and the Sheraton Waikiki.
- Mar. 1-8, 1980 Marquette-MCW Med Alumni Assoc. Clinical Conf. Held on Maui.
- Mar. 10-15, 1980 Diagnostic Radiology including Ultrasound & CT Scanning, Duke Univ. Med Centr. Held at Hyatt Regency, Waikiki.
- Mar. 18-22, 1980 Sports Medicine, Department of Physiology, Princess Kaiulani, 18 Category I credit hours. J. A. Burns School of Med. Contact: Harold Brown, Hawaii Conf. Serv. P. O. Box 25055, Honolulu 96825 (808) 377-6445.
- Mar. 19-25, 1980 Traveling Medical Education Course, Penn. Med. Society. To be held at Kauai Surf.
- Mar. 24-Apr. 4, 1980 Tutor Oncologist-Visiting Prof., Wm. A. Robinson, M.D., Med. Oncol. U of CO. For complete lecture sched. ph. (808)531-1662 Kay VanSant. Hi. Div. Am Cancer Soc.
- Mar. 27-Apr. 4, 1980 9th Obstetrical Anesthesia Conf. Ohio St. Univ. College of Med., Marina Del Rey, CA. To be held at Sheraton Waikiki.
- Mar. 29-Apr. 4, 1980 Infectious Disease Conf., U of Wash. Schl of Med. to be held at Ilikai Htl. 20 hrs. Cat. I.
- Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, John A. Burns Schl. of Med., co-sponsored by the University of Washington, Dept. of Ob-Gyn and Hawaii Section of ACOG, Ilikai Hotel, 24 Category I credit hours, 24 cognates ACOG.
- Mar. 29-Apr. 1, 1980 Infectious Disease Conference, University of Washington School of Medicine, Kauai, 28 hours.
- *Mar. 30-Apr. 3, 1980 Current Concepts of Ob-Gyn, co-sponsored with the University of Washington School of Medicine, Ilikai Hotel, 20 hours credit. John A. Burns Schl. of Med., U of H.
- Apr. 12-19, 1980 Emergency Medicine, USC, Royal Lahaina, Maui-30 hrs. Cat. I
- Apr. 12-19, 1980 Diagnostic and Therapeutic Skills in Internal Medicine, USC Mauna Kea Beach Hotel on the Big Island-30 hrs. Cat. I
- Apr. 19-26, 1980 Orthopedic Review, USC, Mauna Kea Beach Hotel on the Big Island-30 hrs. Cat. I.
- Apr. 26-May 3, 1980 Management of the Surgical Patient, Stanford University School of Medicine, Mauna Kea Beach Hotel on the Big Island, 25 hrs. Cat. I.
- *May 1980 Diving Medicine, 1980 Update, to be held either on the Big Island or Kauai, 35 credit hours. John A. Burns Schl. of Med. U of H.
- May 3-11, 1980 California Soc. of Anesthesiologists, Hotel Intercontinental, Maui; Hyatt Regency, Waikiki, Oahu
- May 10-17, 1980 Pediatric Workshop, USC, Royal Lahaina, Maui, 30 hrs. Cat. I.

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- *May 11-17, 1980 Modern Trends in Emergency Medicine, co-sponsored by National Emergency Services, Inc. and the Hawaii Chapter of Emergency Physicians. John A. Burns Schl. of Med. U of H.
- June 9-11, 1980 Current Concepts in Management in Common Neoplasms, Cook County Graduate School of Medicine, 24 hours credit.

*Accredited and co-sponsored by the University of Hawaii, John A. Burns School of Medicine.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



**December 7, 1979, 5:30 p.m.
HMA CONFERENCE ROOM**

PRESENT:

Drs. Bell, Winn, Lum, Hindle, Goto, Chinn, Iaconetti, Fong, Azman, Miles, Chun-Hoon, Lumeng, Shirasu, Bruce, Cahill, McNamee, Magoun, Wigle, Fu, Simmons, Catts, Dang, Simmons, Florine, Bolian, Nicholson, and Mr. V. Thomas Rice. HMA Staff present were: Messrs. Won, Saranchock, Leineweber, and Ajifu; Mmes. Chang, Kendro, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 5:55 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of November 30, 1979 which indicated that HMA membership totaled 922 in comparison with November 1978 when membership totaled 905.

REPORT OF THE TREASURER:

The October 1979 financial statement was reviewed in detail and approved subject to audit. The Council approved a recommendation from the Finance Committee to give HMA employees an annual bonus of 2% of the annual gross salary, which has been a custom in the past.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Peer Review: Dr. Ann Catts requested that the Council consider a 11/9/79 memorandum from HCMS Peer Review Committee Chairman, Dr. George Schnack, which raised the question of whether the "Impaired" Physicians' Committee should function at the county society or state association level. Consultation was made with the presidents of the county societies and HMA legal counsel.

ACTION:

It was moved, seconded, and passed that issues relating to an "impaired" physician should come under and be handled by each county society's peer review process, with provision for appeal to the HMA Peer Review mechanism in instances where it is not possible for the case to be handled locally.

The Council felt that the county societies should be encouraged to amend their bylaws to include a provision which would give the society the authority to refer such cases, if necessary, to the HMA.

B. Health Fair: In February 1979 the Council agreed that HMA hold a health fair in 1981 in conjunction with the 125th anniversary of the association. In the past months, Dr. Charlotte Florine, Health Fair Chairman, has been researching the concept and the experience of similar fairs. Dr. Florine briefed the Council on her findings regarding the feasibility of undertaking this project and requested further guidance from the Council. The Council decided to reassess its earlier decision to hold a health fair in 1981 in view of changing economic conditions and limited manpower.

ACTION:

It was moved, seconded, and passed to cancel the 1981 health fair. There were two opposing votes.

C. Gerontology Center of Hawaii: Dr. Charlotte Florine, HMA's representative to the Gerontology Center of Hawaii, provided the Council with an update on the activities of the program. It was pointed out that HMA's participation through its representative, Dr. Florine, has been severely limited in that her only role has been to serve on the forty-member advisory committee to the Gerontology Center. Most recently, the preparation and submission of a proposal to establish a Long-Term Care Gerontology Center was accomplished with little input by HMA. The Council expressed concern: (1) that while substantial funds have been expended in the planning phase, there is some question regarding the implementation process and the benefits accrued for the elderly; (2) that project approval by HMA would be implied by being listed as a participant; (3) that the practicing physician must be truly represented and involved in such programs and their development; and (4) that HMA should pursue its own activities in this field.

ACTION:

It was moved, seconded, and passed that HMA withdraw its participation and support in the Gerontology Center of Hawaii as presently constituted.

D. Fee Survey: Reviewed by the Council was a 12/7/79 report from Dr. William Dang which sum-

marized the reactions of the Fee Survey Committee regarding the action of the HMA House of Delegates to *not* publish a RVS in 1980. Dr. Dang also reported on the activity by the FTC in California and the New York Supreme Court ruling regarding the anesthesiology RVS. On behalf of the Committee, Dr. Maurice Nicholson recommended that the HMA Council authorize the publication of a Current Procedural Terminology Manual. The Committee also recommended that the HMA issue an anesthesia schedule based on the national American Society of Anesthesiologists RVS.

ACTION:

It was moved, seconded, and passed that HMA publish a Procedural Terminology Manual, with the decision to include the national anesthesiology codes or to leave them completely out of the publication to be pursued further by the Fee Survey Committee for report to the Council.

E. EMS: Dr. William Dang reported that the EMS Program has embarked on a more intensified public information and education campaign especially for the upcoming holiday season. On December 10, a meeting will be held with DOH representatives to continue discussion on the pending DOH-HMA contract for the EMS Program. Also discussed by the Council was the provision of emergency medical services by fire fighters on the Big Island. Since concern was expressed that there may not be sufficient emergency coverage on the island from the first of the year, it was agreed that HMA write a letter to Mayor Matayoshi, the Fire Fighters Association, and the DOH to express this concern and to encourage them to resolve this matter.

F. Health Manpower: Dr. George Bolian reported that the SHCC Manpower Task Force has developed a report on Physician Manpower which is currently being considered for inclusion in the Third Edition of the Hawaii State Health Plan. Dr. Bolian discussed the involvement of physicians in developing the physician manpower report, which is slated for a public hearing in January. The Council expressed concern regarding the possible future implications and ramifications that these statistics can have on matters such as licensing of physicians, residency training programs, etc. It was felt that these concerns should be discussed by the Health Manpower Committee with specialty societies and the Dean of the University of Hawaii School of Medicine. The Council agreed that a letter be written to specialty societies to request: (1) their input and review of the report, (2) their thoughts on future implications for the particular specialty, and (3) additional information or literature that may be available.

ACTION:

It was moved, seconded, and passed that HMA, through its Health Manpower Committee, consult with the directors of the local residency training programs and the Dean of the UH School of Medicine to engender some dialogue on this data.

G. Legislation: A recommendation was made by the Legislative Committee that Mr. Jon Won be asked to serve as HMA's official lobbyist and that Mr. Kazuhisa Abe be retained as HMA's legislative counsel on a fee-for-service basis.

ACTION:

It was moved, seconded, and passed to accept the above recommendation.

H. Medical Education: Approved by the Council was a recommendation from the CME Committee to use the 1980 Annual Meeting for HMA's reaccreditation site visit. Dr. Nadine Bruce mentioned that physicians have received their application for relicensure which contains a statement to be signed by the physician certifying that he has completed the CME requirements adopted by the Hawaii Board of Medical Examiners.

I. Public Health: Dr. Thomas Cahill reported that the Cancer Committee recently met with Dr. Edward Moorehead of the Grand Rapids Oncology Program to discuss operating in Michigan. With regard to the Chronic Illness Committee, Dr. Cahill reported that HMA frequently receives inquiries from the public requesting referral to a physician who will accept geriatric patients. The Committee will be conducting a survey of the membership to identify those members who are interested in this area.

J. Computer: Mr. Jon Won reported that HMA is in the process of making its computer operational, and it is anticipated that membership and CME programs will be operating by the end of January. The site for the equipment has been prepared at the BME.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Henry Fong reported that HCMS held its Annual Meeting on December 2 at the Honolulu International Country Club. The meeting consisted of a golf tournament, seminar on professional burn-out, and annual banquet dinner. New officers installed at the meeting were Dr. Calvin Kam (Pres.), Dr. Henry Fong (Pres.-elect), Dr. Thomas Cahill (Sec.), and Dr. Nadine Bruce (Treas.).

B. Maui: Dr. Ben Azman reported that Maui County was privileged to have Mr. Tom Rice as its guest speaker on November 20, speaking on a number of medical-legal matters. An outcome of the meeting has been the formation of a committee, chaired by Dr. Wasson, to study the possibility of the Society becoming incorporated. The Society's Annual Christmas dinner meeting will be held on December 15 which will mark the installation of Dr. Andrew Don as president of Maui County. Dr. Azman commented that it was an enjoyable and informative year for him as Maui's president and as a member of the Council.

C. Hawaii: Dr. A. Scott Miles reported that Hawaii County held its last general meeting on November 15 with guests, Dr. Douglas Bell and Mr. Jon Won, giving a presentation on HMA activities. Officers elected at this meeting were Dr. James Lambeth (Pres.), Dr. Ben Hur (Vice Pres.), Dr. Robert Aikman (Sec.), and Dr. Ung Lee (Treas.). The Society's Christmas meeting will be held on Friday, December 14 at the Hilo Yacht Club.

OTHER BUSINESS:

A. HAMPAC: The Council unanimously confirmed the following appointments to the 1980 Board of Trustees for HAMPAC: Drs. Albert Chun-Hoon, Leonard Howard, A. L. Vasconcellos, Richard Ando, Bernard Fong, Roy Kuboyama, Raymond deHay,

Rodman Miller, William Moore, Timothy Wee, Thomas Whelan, Calvin Sia, L. Q. Pang, P. H. Liljestrand, George Goto, E. Lee Simmons, Thomas Cahill, Allan Kunimoto, George Takushi, Richard Fardal, Pete Okumoto, James Matayoshi, Sakae Uehara, Patrick Aiu, Katok Chuang, Peter Kim, Yonemichi Miyashiro, Mrs. George Mills, and Mrs. Jerome Tucker.

B. Auxiliary: Mrs. Nancy Simmons gave the Council an update on activities of the state and county auxiliaries. Recent activities included a November 27 HCMS Auxiliary Guest Day Program; a meeting on November 30 with national Auxiliary officers to discuss AMA-ERF; and a special workshop session on December 3 with Pat Kendrick, Legislative Chairman for the AMA Auxiliary. Mrs. Simmons announced that the HCMS Auxiliary will hold a fund-raising social event for the Hawaii Medical Library on April 19, 1980.

C. AMA Jail Health Care Project: Mr. Jon Won reported that HMA was visited by Jaye Anno, Director of AMA Correctional Programs, on November 29-30. During this time, she provided an orientation on the jail health care project to some HMA staff and met with representatives of the DSSH Corrections Division. Mr. Won reported that by HMA's expression of interest to the AMA, they have considered HMA as a participant in the program. A recommendation was made that the Council formally approve entering into agreement with the AMA for the Jail Health Care Project.

ACTION:
It was moved, seconded, and passed to approve entering into an agreement with the AMA for the Jail Health Care Project.

Plans are being made to hold an orientation session for all jail administrators in the State and also to establish a committee to implement this program.

D. Drug Enforcement: Mr. Won reported that some time ago, the HMA was asked for assistance in drug enforcement activities. Based on legal counsel's opinion, it was the general feeling of the Council that to provide such assistance would technically constitute violation of the law.

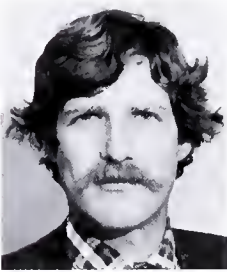
ACTION:
It was moved, seconded, and passed that the

HMA continues to pursue the principle that physicians not violate the laws of the land.

ADJOURNMENT:
The meeting adjourned at 9:50 p.m.



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314 Uluniu Street
Kailua, Hawaii 96734
CARDIOLOGY AND INTERNAL
MEDICINE



Jay L. Grekin, M.D.
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DERMATOLOGY

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DEFENDANTS REIMBURSEMENT INSURANCE



Richard J. Korsak, M.D.

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NEUROLOGY AND CHILD
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PULMONARY DISEASE



John V. Mickey, M.D.

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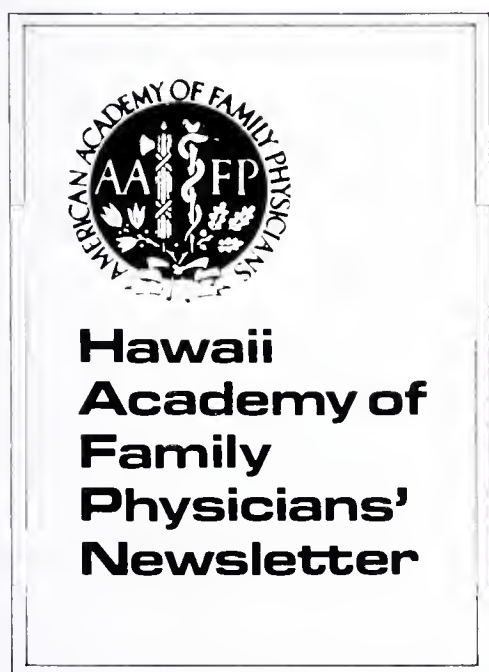
INTERNAL MEDICINE



Stuart A. Souders, M.D.

550 South Beretania Street
Honolulu, Hawaii 96813

RADIOLOGY



J. I. FREDERICK REPPUN, M.D.

Please Note! This is the last NEWSLETTER under JIFR; from now on it will be produced by **Don** and **Marlies Farrell**. Marlies has been appointed our new ExecSec by the Council, to succeed **Jean Reppun**.

New Members—**Pat Lowry** has returned to the Hawaii Chapter as an Active member by transfer from the Arizona Chapter. **Carlos Lam** is a new Student member from the UHSM. Welcome!

Members Dropped or Resigned—**Maynard Olsen** was dropped from our rolls but is continuing as a member of the Armed Forces Chapter on the Mainland. We are sorry to announce that charter member **Toru "Blue" Nishigaya**, despite personal pleas to remain as an Inactive member, has resigned from AAFP; his membership was one of 28 years duration. Student member **Mark Yoshida** has resigned.

News of Members—**George Roger Gay** has returned as an Active member, a Fellow and ABFP, to practice in Hilo, after a stint in California.

Core Content Review—has enriched the coffers of HAFP by \$78.00 as a 10% refund of the registration fees of 13 members of the Hawaii Chapter who participated in this excellent program by mail. This represents 17% of the Active membership of our chapter, which rates us fourth, after Ohio 26%, Connecticut 25.2%, and Illinois 17.9%. CCR is making available a repeat of the material initially started on 1 October, beginning in February, for a registration fee of \$60 for members. Please contact our ExecSec immediately if you are interested in applying, **Marlies Farrell** at 235-3115.

Computerized CME—The Council voted to require that all eligible members use the AAFP Computerized system for CME "P" and "PI" credits henceforth; otherwise, the work of our ExecSec becomes too difficult when it comes time each year to recertify members for re-election to membership. AAFP Headquarters has offered this service to Life, Inactive and retired members who need their CME credits in order to maintain licensure.

Election of Officers for 1980, etc.—The slate of nominees will have been mailed to all members eligible to vote at the annual meeting of HAFP on Sunday, 3 February in the Coral Ballroom of the Hilton Hawaiian Village. Those elected at that time will be installed by AAFP President **Derryberry** during a brief business meeting of the HAFP. The Treasurer's report will be published at that meeting to those present; other members not present may request a copy if interested.

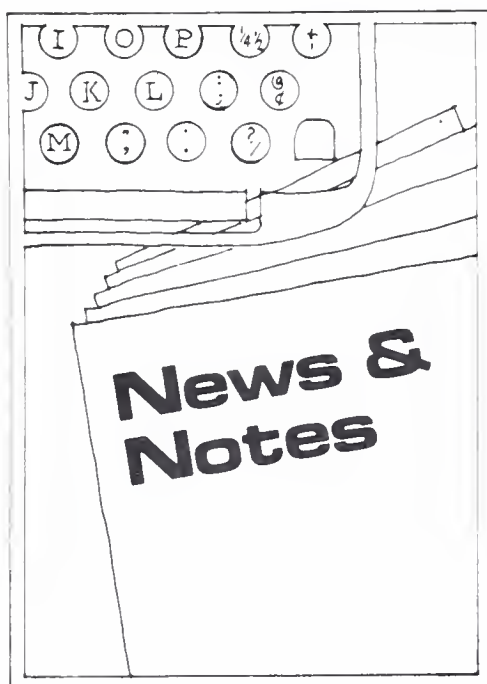
Hawaii Review—This is the last notice in this column of "Hawaii Review," a scientific program put on jointly by the HAFP and the British Columbia Chapter, College of Family Physicians of Canada, 1-4 February at the Hilton Hawaiian Village. Programs and registration forms are available from **Jean Reppun**, phone 239-8383.

CME—There is a wealth of "P" credit courses coming up in Hawaii as well as on the Mainland. Call **Marlies Farrell** for details.

Aloha & Hauoli Makahiki Hou!



"You can eat anything. Just don't swallow it."



HENRY N. YOKOYAMA, M.D.

Pars vs. Non-Pars

Honestly, we had every intention of covering the whole Nov. 5 HCMS meeting with HMSA officials, but it was Monday night football time and the Houston Oilers were playing the Miami Dolphins . . . When we finally tore ourself from the hypnotic influence of the television screen and joined the fray at Mabel Smyth, we were a whole hour late . . . **Satoru Nishijima** was saying, "It is discriminatory to have physicians classified as pars and non-pars . . . As you recall, HMSA was originally organized to cover those patients who could not pay for our services and we voluntarily accepted a cut in fees as participating physicians . . ." On stage was the HMSA trio of **Al Yuen**, **Bernard Ho** and **Bill Sage** while **Walt Chang** and **Calvin Kam** acted as moderators . . . Al Yuen, the master pacifier was explaining, "You're right . . . HMSA was organized for that group of patients who earned less than \$500.00 per year and 10% of the doctors' fees was deducted . . . That is the same situation today . . ." Satoru protested, "You are penalizing those patients who pay the same premium when they go to a non-par physician . . . Have you consulted the attorney general on this matter?"

Bernard Ho came to Al's defense by deftly evading the question: "In Hawaii, every physician has the opportunity to be either participating or non-participating . . ."

(Ed: Why are we writing all this from obviously fragmentary notes and when we had missed the first hour? . . . Well, suave **Fred Gilbert** with his Monty Wooley beard had commented after the meeting, "I just returned from Washington and they think Hawaii's prepaid health plan is the best in the country . . . Yet look at the atmosphere here . . . Henry, why don't you use that facile pen of yours and describe the actual situation" . . . 'Facile pen' eh? Fred had touched a soft spot in our ego, so fragmentary, erroneous, incomplete redundant or whatsoever . . . Of course, we first tried to find out if anyone had taped the meeting because the questions and answers were being spouted so hot and furious that we barely managed to scribble but a few sentences . . . So with apologies for possible misquotes, we shall continue . . .)

Back to the session . . . **Tom Cahill** (who has made a comprehensive study of the par and non-par situation) made some pertinent reference to the Hawaii Dental Plan vs the HMSA sponsored dental plan. Then, he was saying "Your plan makes money because assuming both par and non-par physicians charge \$10.00 an office visit, the par physician is allowed \$9 while the non-par physician is allowed \$7.50 (Referring to the 90 percentile payment for pars and 75 percentile payment for non-pars.) If more HMSA subscribers see non-par physicians HMSA pays out less in benefits. If more HMSA subscribers see par physicians, premiums for HMSA

coverage will rise more rapidly than if these same patients see non-par physicians for the same services. Tom later added that the par physician gets his "usual" fee raised 30 or 60 days after he notifies HMSA of his fee raise while the non-par physician has his "usual" fee reevaluated only once a year in January . . . and his "usual" fee is based on the first 9 months of the previous year—not on his current charge!

Someone in the back lamented, "There are so many things wrong with the entire system that I don't know where to begin. Primarily, the patient doesn't know what he is buying and the difference between par and non-par physicians. In the end, the physician becomes the fall guy as usual . . ." **Gabe Ma's** voice pealed forth: "In your next month's TV commercial, please clarify the difference in your payments between par and non-par physicians . . ." and **Bernard Ho** agreed!!!

Yoshi Oda was furious, "Regarding the question whether or not you are par or non-par . . . It really doesn't matter . . . If you're a cad, you're always a cad . . . But have any of these issues ever been brought to court?"

Al Yuen replied calmly, "The courts have always supported our health plan . . . One of the things we have discussed is that the doctors have complete freedom of choice to be par or non-par . . . We have 525,000 people enrolled and they cannot all be ignorant . . . So there must be something we are doing right . . . I don't think the public is entirely unhappy . . ." Attorney Tom Rice then spoke: "But you don't specify that they will get less money if they go to a non-par." Lee Simmonds also elucidated, "If both par and non-par physicians charged the same fee, then the par physician gets more . . ." Al Yuen seemed to be unsure of himself on this point . . . So Tom Cahill again explained, "Par physicians are allowed up to the 90 percentile of the usual and customary based on their current fees while the non-pars are allowed 75 percentile of the usual and customary . . . based on fees 8-20 months outdated." (After the meeting, **Cal Sia** commented, "I don't think Al really realized that pars were getting more than non-pars when the fees are the same . . .")

Cal Sia tried to bring order to chaos: "We are all consumers . . . The consumer seems to end up paying the same premiums, but receives less by going to a non-par physician. This is the crux of the matter . . . The major issue is that the consumer gets less . . . consumers all pay the same premium but if they see a non-par physician they receive a smaller financial benefit than if they see a par physician." **Bernard Ho** grinned like a Cheshire cat: "We may not please all the physicians, but we please the consumer." Cal was still trying to arbitrate with the disinterested: "We are all trying to work together in containing cost . . . How can we help you . . ." No reply was forthcoming to his enquiry . . . Later **Fred Gilbert** also tried: "What can we non-par and par physicians do to make your job easier . . . Beyond what we have already discussed this evening?" Again no comment . . . **Calvin Kam** tried vainly to moderate . . . He raised a question from the audience: "Are there different fees paid according to locale?" Al Yuen answered, "When we first started, yes. But this situation has now been rectified."

Another question regarding RVS coding and schedule was brought up. Al Yuen replied, "We have to sit tight on the RVS for the present."

Question: "In the selection of board members, why isn't a non-par physician on the board?" Al Yuen was quite frank: "Getting a physician sympathetic to the plan is important. It is a purely democratic process . . ." But Al neglected to explain why it was such a pure democratic process . . .

Question: "Why is Plan 65 C so slow in being processed?"

Bernard Ho replied: "We are considering making arrangements with Aetna for use of their tapes to expedite Plan 65 C payments."

Al Yuen later became conciliatory: "I think you and I are on the same side of the street . . . The National Fee Schedule is one . . . We'll be subsidizing the high cost areas with its adoption . . . Even regionally, I think is wrong . . . We should adopt individual state fee schedules . . . Cec Heftel, members of Dan Inouye and Spark Matsunaga's staffs are aware that Hawaii's Prepaid Health plan is the best . . . Adopt Hawaii's plan and there will be no need for a national health plan . . ."

(Dear Fred . . . We hope our 'facile pen' documented some of the 'sound and fury' of the confrontation . . . We deliberately omitted some of the more violent outbursts simply because we became so fascinated with the vehemency that we plumb forgot to jot down their comments . . .)

Life In These Parts

Former HMA president **George Goto** (who now jogs 5 miles after his bypass surgery) was quietly sipping a soft drink at the House of Hong's reception for the Hiroshima Medical Association delegates. **Yasuhiko Yano** being present in the throng, we encouraged George to drink a little alcohol since Yasuhiko had evoked a *New England Medical Journal* editorial comment with his epochal study showing that moderate drinkers have less coronary disease than teetotalers . . . Carolyn scowled, but George ordered a Heineken's and looked happy . . . Next day, Yasuhiko lectured at the Hiroshima-Hawaii scientific session that drinking 4½ beers did not necessarily prolong life because those who drank developed more cancer and liver ailments, although cardiovascular ailments were less. That evening at the Nuuanu Onsen reception, we found a forlorn George again sipping a soft drink . . .

The early January storms have wreaked havoc with electrical and telephone lines . . . **Willard Miyahira** asked us at the KMC Waikiki III nurses' station how we had fared and we related how our electricity had been cut off for half an hour. Willard, who lives in the golf course subdivision, related how his electricity was out for 12 hours, and his telephone was still disrupted (since 3 days ago) . . . Willard however, did not look unhappy . . . As a matter of fact, he smiled happily and commented, "I've been sleeping well . . ."

We noticed an intriguing neon sign above a corner hardware store in Moiliili which read, "New Year's Special . . . Elopement Ladders . . ."

A green Toyota pickup passed us on the H-1 freeway and we had to smile . . . It had a bumper sticker which said, "Happiness is a good screw . . . Nevada Nuts & Bolts, Inc."

When we made our usual delinquent rounds at CCH, the clerks and nurses effused, "Thank you so much for coming, Doctor!" We asked defensively, "Am I the worst offender?" "No, Doctor, you are only the second worst . . . **Dr. Kuramoto** is by far the worst." We were relieved . . .

Posted on the bulletin board on Makai V was the following poster: "Notice To All Employees, To Save Time Please Give Excuses by the Numbers:

1. The computer fouled it up.
2. I didn't know it was that important.
3. Don't blame me. I was hired for my looks.
4. That's not my department.
5. No one told me to go ahead.
6. I've been too busy.
7. We've always done it that way.
8. I forgot."

After the erudite lecture by James Ferrendelli, visiting professor of clinical neuropharmacology from Washington U, on cyclic AMP and cyclic GMP, **Francis Kaneshiro** (who was in the rear of Kam Auditorium and presumably had some difficulty seeing the slides) asked us quite innocently, "Why was he talking about Gross National Product?" and we naively tried to explain that it was GMP, not GNP . . .

Greatest Wishes For 1980

(Ala Dudley Seto)

Master wit **Dudley Seto** MC'd his own New Year's Eve party at the Regency Ballroom and regaled us with his keen observations of his friends . . . (Our apologies to Dudley if we failed to get everything down on paper.)

Ike Nadamoto: He's noted for his chain smoking . . . His greatest wish for 1980 is a large enough ash tray . . .

Jimmy Wong: Avid fisherman . . . His greatest wish is to go fishing 6 months out of the year in Alaska . . .

David Pang: He's always so immaculately dressed in suits . . . His great wish would be to wear Aloha shirts like **Lester Yee** . . .

Lester Yee: He's always so casually dressed . . . His greatest wish for 1980 is to wear suits like **David Pang** . . .

Ghim Yeoh: His greatest wish for 1980 is not to worry about business this coming year . . .

Noboru Oishi: His greatest wish is to be cloned so he can be in two places at the same time . . .

Clarence Sakai (proctologist): His greatest wish is never to have to do a procto on an unprepared patient . . .

Ed Chesne (cardiologist): His greatest wish is not to have to explain to an orthodox Jew patient that he needs a porcine heart valve and that it needn't be kosher . . .

Grant Stemmerman: His greatest wish is to be able to hike all the way up to the Mauna Kea summit without getting SOB . . .

Frank Fukunaga (pathologist): His greatest wish is not to be called for stat lab work after midnite . . .

Takuji Hayashi (pathologist): His greatest wish is for a pair of bifocals so he won't have to switch glasses when doing electron microscopy . . .

George Goto (former HMA president and great lobbyist): His greatest wish is to be able to retire from medical politics . . .

Masaru Koike (whose daughter married recently): His greatest wish is to not become a grandfather within the next 6 months . . .

Al Chun Hoon: One of the first lichee trees planted in the islands was at the Chun Hoon Market and it has never borne fruit . . . His greatest wish is that the lichee tree will bear fruit . . .

Al Pavel (avid sailor): His greatest wish for 1980 is to own a fully automatic sailboat which doesn't need a crew so he won't have to yell at his family crew members . . .

Marc Shlachter (Kahaluu physician and fisherman): His greatest wish is to be able to spend more time net-fishing than practicing medicine . . .

Dick Warsnick (nuclear med man): His greatest wish is not to have any patient suffocate when doing a perfusion-ventilation scan . . .

Ed Yamada (Assistant Chief of Staff and chairman of every other hospital committee): His greatest wish for 1980 is not to be appointed chairman of any more committees . . .

Mel Kaneshiro (Who gets up at 4 am to jog): His greatest wish is to be able to finish the marathon in 2 hours 30 minutes . . .

Gene Matsuyama: His greatest wish is that the dietician will continue to supply the Dept of Medicine meetings with meals . . . (**Owen Kaneshiro** piped up and added: "And not to have to wear a tie . . . And also to bag a record sheep") (Gene had recently spent two days on Molokai Ranch without firing a shot.)

Ray De Hay (One of our first internists in Kailua, who more recently has been wearing slippers to meetings): His greatest wish is that no one will ask why he wears slippers . . .

Ijaz Rahman (who pours black pepper on everything he consumes): His greatest wish is not to get ulcers from hot food . . .

Tom Sakuda: His greatest wish is to do more dancing with his wife . . .

Malcolm Ing (who shows little trace of his Chinese ancestry): His greatest wish is not to be asked how he got a last name like Ing . . .

Sorrell Waxman (pediatrician): His greatest wish is to have a patient who won't cry . . .

George Suzuki: His greatest wish is for a list of his patients which shows who and where they are so he doesn't have to wander through the hospital . . .

Yutaka Yoshida (who has suffered from tennis elbow for over 25 years): His greatest wish is for a sure cure for tennis elbow . . .

Max Urata (wine connoisseur): His greatest wish is for a deep, deep wine cellar . . .

Herb Luke: His greatest wish: to not to have his name spelled Look . . .

Roger Ogata (who uses bee sting therapy for some of his arthritics): His greatest wish is to not get a killer bee mixed with his honeys . . .

Bill Won (neurosurgeon): His greatest wish is for a non-surgical cure for neck strain . . .

Fred Kuge: His greatest wish is to get a hernia lifting weights . . .

Bill Shiraki: His greatest wish is to be able to spend more time painting . . .

Paul Sunahara (dermatologist): His greatest wish is for patients who won't complain when he is digging into their acne . . .

Larry Wong: His greatest wish is to not perpire when eating . . .

Professional Moves

Somehow we seem to have missed the August announcements, so here we go . . . **Allen B. Richardson** associated with Orthopedic Associates of Hawaii, Inc at Queen's POB; urologist **Clarence Hodges** joined Andrew L. Morgan MD, Inc at Queen's POB; radiologist **Paul Kamin** joined Kuakini Radiology Group, Inc at KMC; and orthopod **Stephen Hirasuna** opened his office at Kuakini Medical Plaza . . .

Then we move onto November, a very busy month . . . Pediatrician **David Wood** joined the Straub Clinic at its Aiea Office, internist **Lawrence Winter** joined **Dudley Seto** at 23 So Vineyard Blvd, internist **Fred Myers** joined The Fronk Clinic—Pearlridge, **Gerald Ching, MD, PHD** opened at 324 Kuulei Road Kailua for pediatrics and generics counseling, and **Niranjan Rajdev** of the Honolulu Medical Group, Inc opened an office in Hilo for hematology-oncology clinical services. Into the Kuakini Medical Plaza moved gastroenterologist **Stanley Shimoda**, internist **Vincent Shiro Aoki**, and cardiologist **Roy Kamada**. **James Ball** announced his resignation as director of the Department of Nuclear Medicine at QMC. On the Big Island, plastic surgeon **John Paopao** opened his office at The Medical Center, 670 Ponahawai Street, Hilo, but most of the activity is in West Hawaii, where **T.A. Barker** and **K.E. Grant** incorporated as Mauka OB-GYN Associates, Inc; internist **Pachnee Pathomvanich** joined surgeon **D. Pathomvanich** in Kailua-Kona; and **Jim Mayer** began family practice at the Boone Clinic . . .

In December, plastic surgeon **Katsuji Kubo** of the Honolulu Medical Group opened an office at Kona Medical Associates' Kealakekua Office; neurosurgeon **H. William Goebert** (who finished law school) joined the Kaiser-Permanente Medical Care Program, where he will practice neurosurgery. Internist **Carl Makarewicz** also joined the Kaiser Program's Koolau Clinic. Cardiologist **Roger White** joined the Straub Clinic . . .

In early January, urologist **Masaru Koike** relocated to the Kuakini Medical Plaza and ENT man **Edwin Dierdorff** relocated to 314 Uluniu Street, Kailua. Pediatrician **Harold Sexton** announced his retirement from the Aiea Office of the Straub Clinic . . . where pediatricians **Vincent McCarthy** and **David Wood** will assume his practice . . . Pau for now . . .

123rd Annual Meeting Banquet

(Ilikai Pacific Ball Room 10-12-70)

The Annual Meeting Banquet was a most delightful interval, for the speeches were deliberately concise, the menu exquisite Chinese, and the entertainment superb . . . President **George Goto** called things to order and the invocation by Rev Richard Du Fresne was pleasant. George then acknowledged our friends and guests, eg, George Yuen, Donald Ching, Pat Saiki, Jack Suwa, Glenn Masunaga, etc etc. **Phil McNamee**, Public Affairs Commissioner, presented the Medical Journalism award to Kathy Tichen, Advertiser medical writer, for the 2nd straight year, for her series on nursing. **Cal Sia** finally won the A.H. Robins Physician of the Year Award after being a runner up candidate for several

consecutive years . . . Following a brief presidential address, we were treated to a "Journey Through Music" by Cindy and Cathy Goto & Friends . . . Lovely, diminutive soprano vocalist Cathy Goto reminded us of Lily Pons as she and her group led us through a melody of such familiar songs as The Toreador Song, South Pacific numbers eg. Some Enchanted Evening, and other Hawaiian numbers, including "Honolulu" etc, etc . . . It was heavenly and we soared with the music . . . The rest is ancient history: viz, AMA President **Hoyt Gardner's** remarks, the traditional installation of new HMA officers, the awarding of the "Broken Cane" Award and Gavel to newly elected HMA president **Douglas Bell** and the call for adjournment by new HMA president Doug Bell. George Goto as retiring president heaved a great sigh of relief . . . It was a most memorable evening for everyone . . .

Miscellany

Tom and Helen were golfing at the country club one Sunday afternoon . . . "Honey," she asked, "If I should die, will you remarry?" "Only if you would do the same, should I die first," he replied. "Would she come to live in our beautiful house?" she pursued the subject . . . "Well, perhaps . . . No reason to move elsewhere, considering how new houses cost nowadays." "Would she sleep on our bed?" "Well . . . It's a new water bed and so very comfortable . . ." "Would you let her use my golf clubs?" she quizzed . . . "Oh, no!" he replied, "She's left handed." (As told by Mary Leinweber, artist, lady and Tom's wife). [Applause!-ED.]

Life In These Parts

AMA President **Hoyt Gardner** of Louisville speaking at the opening ceremonies of the 1979 Interim Meeting of the AMA's House of Delegates asked members to "reverse the growing disenchantment of the American public toward the medical profession . . . The advances in medicine over the years have tended to make us more professional, but less human and soulful, at least in the eyes of our patients. There are ways of making ourselves more human without undoing any medical advances . . . It is important for doctors to respect the patients' point of view—to see them as persons."

When the House killed President Carter's proposal to impose mandatory controls on rising hospital costs, Rep Cecil Heftel voted to kill the mandatory features of the bill while Rep Daniel Akaka voted to keep them . . . In all, 99 Democrats and 135 Republicans voted against mandatory controls and 158 Democrats and 8 Republicans voted for the controls . . .

Gregory Bottum, chief of the Kalihi-Palama Community Mental Health Center feels that the word "mental" is a derogatory local expression and the source of a communications gap between the center and the community . . . "They hesitate to take advantage of our services because of the stigma attached to mental."

From *Advertiser* columnist, Don Chapman's column, "MEDICAL MENAGERIE: Which local gynecologist took his 'overweight' dog to the vet one day and brought her home with six puppies the next? . . . And which Kaiser doctor joined friends from Queen's for a costume party at Trapper's wearing heavy makeup, false lashes and a see-through gown that came off in a spirited striptease? Once known as Karl, friends now call him Karla . . ."

President Henry Yim and the Hawaii Chapter of the American Academy of Pediatricians have been pushing hard for children's seat belts this past year . . . In Hawaii between 1973 and 1977, there were 713 traffic fatalities, of which 16 were children under age 4. Henry points out, "For children over a year, vehicle crash injury is the leading cause of death . . . Why should children be put in jeopardy? No one speaks up for them. They're the neglected minority on the nation's highways."

Yoshitsugi Hokama professor of pathology at the UH School of Medicine and a member of a 15 member ad hoc Ciguatera Advisory Committee, has sharply criticized the

DOH for dragging its feet in warning the public that the fish they catch may contain deadly toxin. DOH statistics show 21 reported cases of "ciguatera poisoning" affected 68 persons in 1979 as compared to 15 cases affecting 42 persons in 1978. In 1977, only two cases were reported and in 1976, only one suspected incident. Hokama says, "We think it's a very serious problem and something should be done. The DOH is not taking the necessary steps—we're quite upset." He suggested that the DOH take a more active part in warning people about the growing ciguatera menace.

Norman Goldstein's book, "The Skin You Live In" will be condensed in the March issue of *Cosmopolitan* magazine. The title of a forthcoming book is "The Skin You Love In" and came from a Rabbi Julius Nodell . . .

Elected, Honored & Appointed

We congratulate belatedly our newly elected HMA officers who were elected back in Oct . . . viz president **Douglas Bell II**, president-elect **Neal Winn**, secretary **K. Y. Lum**, and treasurer **William Hindle** . . . We next congratulate our new HCMS officers who were installed in Dec . . . viz president **Calvin Kam**, president-elect **Henry Fong**, secretary **Thomas Cahill**, and treasurer **Nadine Bruce**. Pats on the back for jobs well done are due outgoing HMA president **George Goto** and outgoing HCMS president **Walter W.Y. Chang** . . .

On the national front, pediatrician **Richard Ando** was appointed to the National Advisory Council on Child Health and Human Development, by Patricia Harris, new secretary of HEW. **Ann Catts**, Queen's pathologist and past HCMS president, was selected to serve on the AMA Ad Hoc Committee on Women Physicians in Organized Medicine. **John Smith** of the Honolulu Medical Group was named president of the Western Orthopedic Association . . . **Ralph Hale**, chairman of the OB gyn Dept of the UH Med School, was elected president of the Pacific Coast Fertility Society . . .

On the local front, **Cal Sia**, past HMA president was named committee chairman of the state advisory committee to the 1980 White House Conference on Families by Gov Ariyoshi. **Stanley Batkin**, professor of surgery and physiology at the UH Med School, was inducted with 11 graduating med students into Alpha Omega Alpha, the honorary national medical society . . . **William Montgomery** was appointed to the American Heart Association's Emergency Cardiac Care Committee . . .

On other fronts, OB man **Yorio Wakatake**, age 72, who has long been associated with Aikido, was awarded the 5th Class Order of the Sacred Treasure . . . Internist **Jack Ikeda** received the Silver Anniversary Citation for 25 years of service to mankind at an alumni banquet of Creighton University School of Medicine in Omaha, Neb . . . Three Honolulu surgeons, **George K.T. Chung**, **Ulrich Stams**, and **Kent Davenport**, were elected Fellows of the American College of Surgeons . . . **Melvin Kaneshiro** was elected to the Kuakini board of directors . . . **Edward Colozzi** was elected president of the Honolulu County Chapter of the Muscular Dystrophy Association . . . **Gwendolyn Nishimura** of Honolulu became a diplomate of the American Board of Family Practice. Also new diplomates of the ABFP are **Takemitsu Esaki** of Ele'ele and **Robert Overlock** of Waimea . . . **Arch Wigle** of Pahala was recertified as a diplomate of the ABFP . . . **Sakae Uehara** was recently commissioned to serve on the State EMS Advisory Committee . . . **Anna Maria Brault** was named chief of the Communicable Disease Division of the DOH, filling a post vacated by **Ira Hirschy** . . . At the International Society of Tropical Dermatology's Fourth World Congress in New Orleans in October, **Olaf Skinsnes** won the society's scientific award for a presentation of leprosy studies in human and armadillo tissues. **Norman Goldstein** won the cultural-historical award for his exhibit, "The World of Tattoos."

Hors De Combat

Michael Neil McKee, age 25, who won honors at the University of Vermont Med School, was a first year resident

in internal medicine at the University of Hawaii Med School . . . **Irvin Schatz**, chairman of the Dept of Medicine, regarded him as the brightest of the group and said, "He had little or no use for the artificial in our lives. . . I think he would have been outstanding no matter what field he'd gone into." Michael played baseball, soccer and tennis, and skied frequently in Maine and graduated *cum laude* from prep school. At the University of Maine, he was on the dean's list. He reveled in the water and swam frequently in a seven mile lake . . . On Oahu, he jogged regularly and played tennis. Michael had everything going for him till that tragic day in December when he was knocked from his feet and dragged into the surf at Hanakapiai Beach around 2 pm. When Michael's companion, a fellow doctor, hiked out of Hanakapiai and called for help about 4:45 pm, the police referred her to the Fire Department and to Chief Silva, who callously said he was not willing to authorize spending money for a helicopter search . . . "Poho you go search the area when there's nobody there . . . When the current's strong, if you not one good swimmer, you drown. A good swimmer will get out of there . . ." (Ed But apparently he was a good swimmer . . . What a loss which no one can even attempt to equate in terms of the dollars and cents of the cost of a helicopter search . . .)

The Federal Trade Commission says the AMA is illegally restraining competition among members by restricting their advertising and solicitation of patients, but FTA ruled that the AMA may formulate "reasonable ethical guidelines" governing acceptable advertising. The 4-year FTC case was brought amid a series of rulings giving lawyers, engineers, druggists, and optometrists the right to advertise by barring ethical rules against such ads. The AMA is expected to appeal the FTC ruling to a federal court, although it has *never* forbidden physicians to advertise and does not want to do so now. Strange case!

Honolulu gynecologist **Donald Nicol**, who was cleared of two misdemeanor charges of sex abuse earlier last year, has filed a lawsuit in Circuit Court over the allegations which led to the criminal proceedings. The complainants were patients in KMC in July 1978 while Nicol was in the residency program . . .

When Big Island firefighters, who were trained with EMS funds, threatened to stop performing voluntary paramedic duties because they were short on manpower for fighting fires. The DOH gave the International Life Support Inc (which has a similar contract with Maui and Kauai) a \$1-million contract to take over ambulance and emergency medical service. Now those firemen trained as paramedics are moonlighting for the new private service in their off-duty hours. The Big Island Fire Chief Donald Thompson and the fire fighters union leadership have given their blessing to the moonlighting . . .

Maui physicians **William Gintling**, **Donna McCleary** and **David Kosnick** have voiced concern about a growing number of women who are having their babies at home with the help of midwives, rather than opting for a hospital setting with an obstetrician and pediatrician on hand . . . In October, there were two cases in which the mothers and infants suffered adversely from home delivery by unlicensed midwives . . .

Hawaii has 2,700 handlers of controlled substances. Drug enforcement officials say that while Hawaii ranks 42nd among states in the number of controlled drug handlers, the per capita consumption of certain controlled substances in Hawaii is disproportionately high compared to other states. Hawaii was the 14th state the federal government targeted for a drug diversion investigation unit. In 1978, 84,000 prescriptions were written for the most frequently abused drugs, viz, quaalude, secobarbital, amphetamines, Demerol, and morphine. The most recent physician indicted by a grand jury is a Kona physician who had 14 criminal counts related to selling legally prescribed narcotics to persons who resell the drugs illegally . . .

Physicians Speak Up

Richard K.C. Lee, director of the University of Hawaii Research Corporation and former dean of the School of

Public Health visited China in July and August as part of a health care consultation team under the auspices of WHO. Richard told members of the China Seminar that "While respiratory diseases are still the number one killer in China, cancer and heart diseases are high-priority health problems on which the Chinese are doing extensive research, screening, and treatment . . . Although stomach and lung cancers lead the list, the Chinese are most interested in liver cancer, esophageal, and nose and oral cavity cancer. All of them have a high incidence in certain regions, and have a high mortality rate unless detected early and treated."

Hilo Hospital pathologist **Stephen Woo** was present at a two-hour public hearing of the Hawaii County Council in November on a proposed dog leash law. Stephen explained that dog feces contain certain parasites that could attack young children and suggested the ordinance should spell out specifically how to dispose of the droppings . . .

In November, **Robert J. Latta** wrote: "What has happened to the rights of children? The current UPW strike has demonstrated that children, the ultimate victims, apparently have very few rights at all. Children have no power to affect the outcome of this struggle. Nevertheless, these innocent young hostages have been deprived of their constitutional right to an equal and free education . . . Remember, 1979 is the International Year of the Child. Children are our most precious resource."

David Rodwell wrote: "Waikiki deserves a name change. About five years ago, the state flower was changed to condominium and the state bird became the ubiquitous crane (you can see them everywhere sitting on top of tall buildings) So I suggest that Waikiki be changed to 'Concrete Canyon' or 'Snipers Alley.' "

Pediatrician **John Briley** of Maui says, "Football should be for physical fitness and fun . . . not the extension of the parent's desire to be a star. It's an ego trip for the parent . . ." Regarding the prevailing attitude that injury is as much a part of football as a touchdown, and that the game is reserved only for those macho enough to risk injury, John is quite explicit: "That macho image of being a tough guy is a lot of crap."

When DOH psychiatrist **Dennis Mee-Lee** was quoted as saying that it is hard to treat someone who does not think that he is mentally ill and that the mental hospital is forced by the courts to keep patients after they have been treated, Elizabeth Adams pointed out that "under the provisions of the penal code, the hospital can apply to the court for conditional release of the patient at any time after commitment. Sometimes a problem has arisen (the Waikiki sniper is an example) when the hospital has circumvented the law and released patients without court consent. The fault here is not with the court or with the law, but with the administration of the hospital. It is really time for Hawaii State Hospital and the Mental Health Division to stop blaming everybody else for their operating difficulties."

John Corboy was understandably upset by attorney Arthur Reinwald's statement in Sanford Zalburg's series "Lawyers: A New Image," comparing attorney fees of \$100 per hour with "going to a physician who charges as much as \$400 an hour" (by cramming appointments). John wrote: "I challenge this statement, and ask Reinwald to cite a single example of a physician grossing this hourly amount in the office . . . Most physicians would be delighted to gross \$100 per hour . . . Even were a physician to work twice as fast, he'd never get close to the figure Reinwald cites by any combination of new or follow-up visits . . ." Then John applies the coup de grace with: "Attorneys desirous of a 'New Image' ought to dispense with invidious comparison and stick to the facts, lest the public question their motives or integrity."

On yet another occasion John Corboy brings out a point which continues to boggle our minds, viz, Medicare allowances: "Sanford Zalburg's excellent coverage of the problems of Medicare skipped one of the key difficulties: the failure of Medicare officials to forthrightly explain what they mean by 'reasonable' charges on which their reimbursement is based . . . The implication is that if Medicare payment doesn't cover the doctor bills, the physician's fees are not 'reasonable,' so cannot be 'allowed' by Medicare . . . With persistence, one

learns that the local office uses the antiquated 1964 issue of the Hawaii Relative Value Studies, listing procedures on which it says it will pay 80% of 'reasonable' charges. A 'reasonable' charge is defined as the 75th percentile of the 'base year' . . . But the base year is always at least a year ago, so what's called a 'reasonable' charge today is only 75 percent of the 1978 charges. In other words, charges in excess of 75 percent of last year's charges are unreasonable . . . Then, claimants receive 80 percent of this 75 percent, or about 60 percent of last year's charges. That's bad enough, but to conceal the truth behind a shrug about unreasonable doctor's fees is a shame. We're all small proprietors in a labor-intensive, service business, exposed to 1980 costs on all fronts . . . For once, physicians would appreciate a simple, honest statement from Medicare: 'In periods of high inflation, this supplementary insurance should not be expected to cover more than one half of reasonable current costs.' " (Methinks the situation with HMSA is worse, esp with regards to par vs non-pars)

Sportsmen

Final standings HMA Doubles Tournament held Sunday am Oct. 7, 1979 at Payless Courts:

1. **Gerald Derricks—Ben Chang**
2. **Frank Lu—Wilfred Tashima**
3. **Gene Doo—Calvin Sia**
4. **Charles Ching—Noberta Baysa**
5. **Worldster Lee—Dennis Maehara**
6. **Yutaka Yoshida—Henry Yokoyama**
7. **William Hammon—Jerry Mayfield**
8. **James Musgrave—Eugene Wong**
9. **Walton Shim—Alex Roth**
10. **Virgil Jobe—Niall Scully**
11. **James Bennett—Victor Dizon**
12. **Carl Lum—Sydney Wong**
13. Tie: **Gordon Ontai—George Shimomura; David Des Jarlais—Eugene Ferris**
15. Tie: **Reginald Ho—Panu Limpisvasti; Patrick Walsh—Ronald Peroff**

Novice Class

1. **Patrick Walsh—Ronald Peroff**
2. **James Mertz—Phillip Hellreich**
3. **Jose Romero—Andrew Don**
4. **Walter Watt—Walter Chang**

Courtesy, **Ken Kern**, HMA Tennis Tournament chairman.

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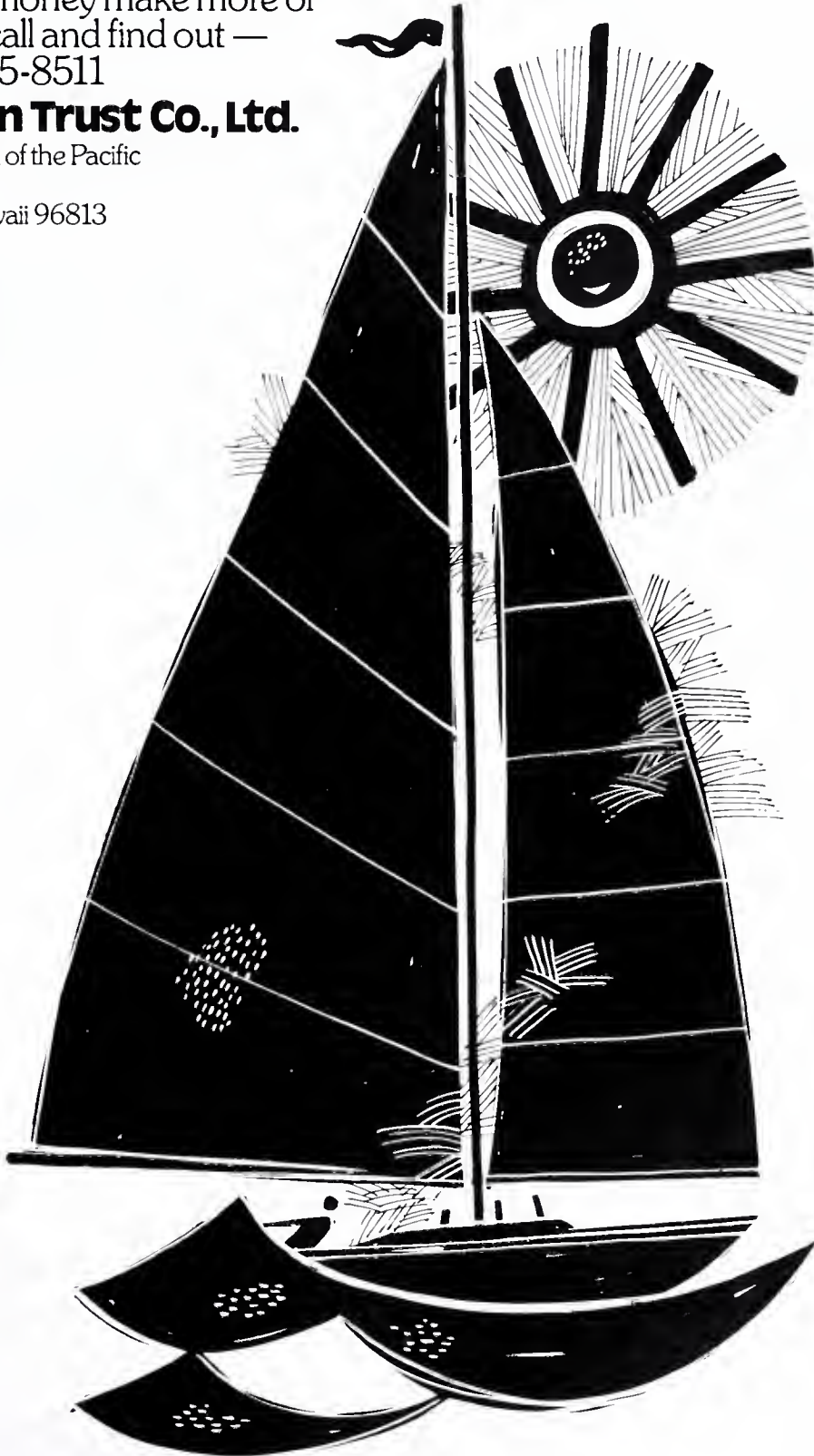
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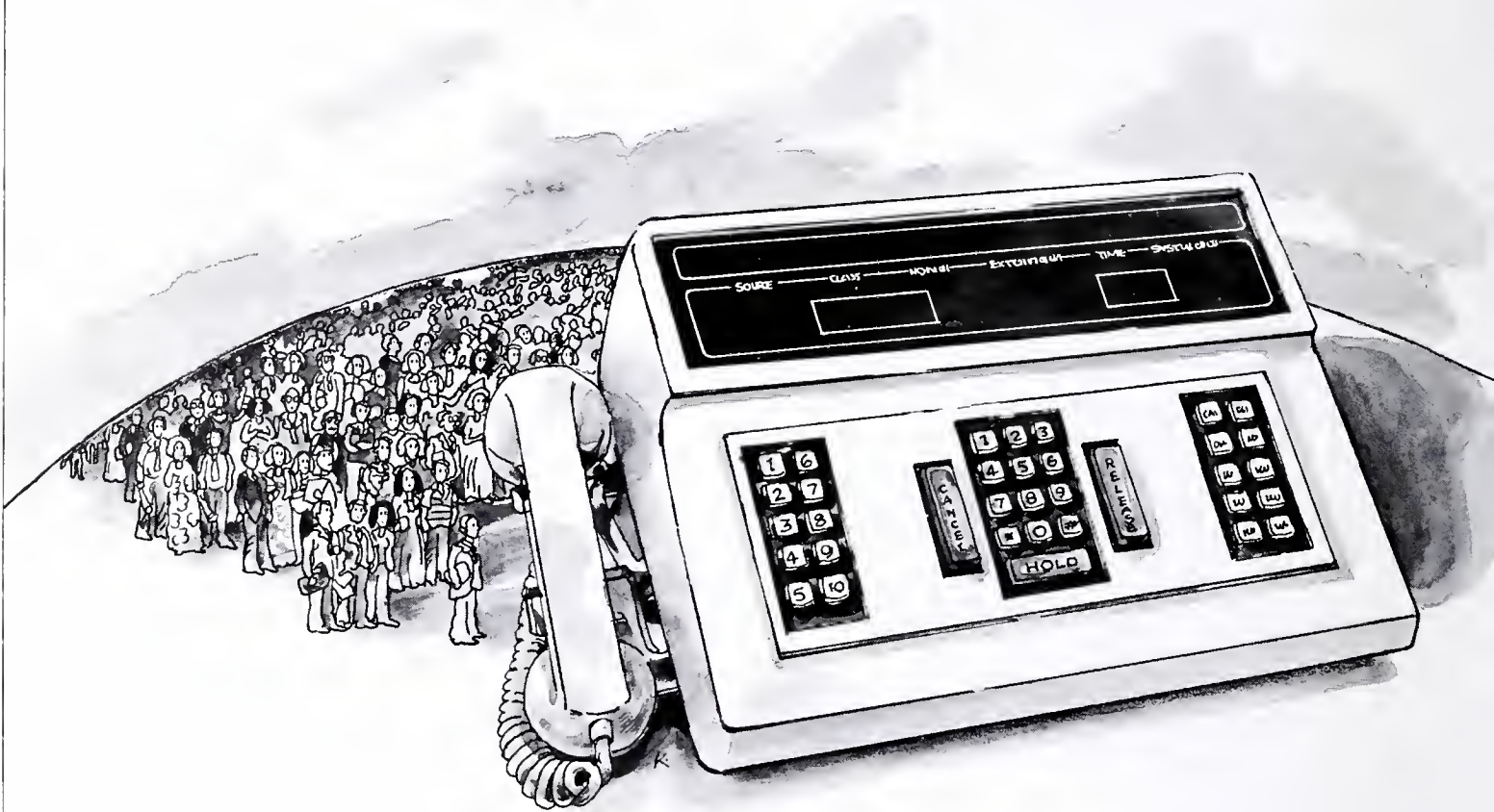
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Some Health Problems of Women Flight Attendants in the Pacific

DORIS R. JASINSKI, M.D., M.P.H., *Honolulu*

● *Honolulu, Hawaii, is the air and sea “crossroads of the Pacific.” Numerous intercontinental flights stop-over at Honolulu International Airport. Numerous flights originate in Honolulu for the South and Western Pacific, Canada, Alaska, and Asia, as well as for the mainland U. S. daily or weekly.*

The present paper discusses some health problems encountered by stewardesses based in Honolulu, passing through Honolulu, either working or on leave, or at home on leave from base elsewhere.

In a general practice, adjacent to the campus of the University of Hawaii, over a 4-year period, 1973-1977, a total of 21 female flight attendants was seen for medical problems, either on a single-visit basis, or in an on-going “primary care” situation. A total of 99 patient visits was recorded (Table 1).

TABLE 1.—Number of Visits	
VISITS PER PATIENT	NO. OF PATIENTS
1	5
2	3
4	2
5	2
6	1
7	1
8	1
10	1
11	2
13	1
14	1
18	1
Total 99	21

The age range of these women flight attendants was 25 to 32 years (Table 2). Their ethnic distribution was as shown on Table 3.

Most of the stewardesses were employed by Pan American and based in Honolulu. Others

Accepted for publication March, 1979.

A version of this paper was presented at the 25th International Congress of Aviation and Space Medicine at Helsinki, Finland, in September, 1977.

TABLE 2.—Year of birth	
1944	— 1
1945	— 2
1946	— 1
1947	— 4
1948	— 6
1949	— 2
1950	— 1
1951	— 1
1952	— 3

TABLE 3.—Ethnic Extraction	
13	— European-Ancestry White American
2	— Afro-American
1	— Spanish Puerto Rican American
1	— Asian American (on leave)
1	— Mexican
1	— English (on leave)
1	— Dutch (on leave)
1	— Thai

were passing through Honolulu. One Chinese-American woman, born and raised in Honolulu, was based in New York with TWA and was home on leave.

The “Complaints by Organ System” are noted in Table 4.

The most frequent health problems involved respiratory problems, sometimes of prolonged duration. In at least 2 cases, allergic rhinitis com-

TABLE 4.—Organ Systems Involved	
NO. OF COMPLAINTS	
Skin	11
Nervous System	8
Respiratory Tract	50
Upper	34
Lower	16
Gastrointestinal	11
Genitourinary	33
Musculoskeletal	10
Miscellaneous	7

plicated the course of repeated respiratory infections.

Many of these women had grown up in small communities and apparently had limited exposure to respiratory viruses in their youth. Exposure on international air routes to respiratory infections was a major factor in illness in 50 instances.

Work-Connected Disability

Table 5 shows "On the Job Injuries." One known death occurred in this group. That was in the crash of the airliner on which the stewardess was working, "on final approach" to the landing field in American Samoa.

TABLE 5.—On-the-Job Injuries

Death in Airliner Crash	1
Muscle Spasm post traumatic (air turbulence)	1
Neuropraxia (coffee spill—arm)	1
Otitis Media (nasal obstruction—pressure changes)	1
Bronchitis (Viet Nam refugee flight)	1
Lumbo-Sacral Disease (from lifting baggage)	1

The patient seen the most times (18) complained of mental fatigue early in our acquaintance, apparently related to a recurrent tracheo-bronchitis and to loss of expected leave because of transfer from another region to the Pacific. She requested grounding. She also tested in the moderately depressed range, on the Zung Scale, at the time she complained of "mental fatigue." (Viral and other infections have been reported to cause depressive symptoms.)

In the more recent past, she had been fairly well and her only problem had been anococcygeal muscle spasm, apparently related to sitting down hard on a pointed object during air turbulence, while on the job.

One stewardess had hot coffee spilled on her arm during a flight. Following this, she was unable to pick things up with the affected arm, in spite of no burn or other disfigurement being discernable. I suspected she was malingering and sent her to an orthopedist for further evaluation. He diagnosed her problem as "neuropraxia." After about one month, the patient's arm strength improved sufficiently for her to return to work.

Another young lady had severe allergic rhinitis with obstruction of her nasal passages and coincidental defect in one eardrum. That this case was at least partly work-connected was disputed by the company, but was finally accepted as a work-associated problem.

One who complained of recurrent "sinusitis" and head congestion said her "sinuses" were better when she was flying. This patient also de-

veloped lumbosacral disease and apparently had "disc" surgery. She was claiming on-the-job injury from lifting food canisters, suitcases and other heavy objects. She also showed signs of depression during one period.

Skin problems were transient and the most annoying ones are listed on Table 6.

TABLE 6.—Skin Problems (in 8 Patients)

Allergic Dermatitis	3
Drug Reaction	1
Eye Cosmetic	1
Sunburn with Impetigo	1
Staphylococcus infection	1
Pediculosis Pubis (Lice)	1
Pedunculated Mole	1
Seborrhea of Scalp (wore a wig)	1

Neurotic Problems

Complaints referable to the nervous system (Table 7) were reported by 8 flight attendants. There are more than 8 complaints, since, in some cases, one person had several complaints, simultaneously or sequentially. Complaints included headaches, one with fainting, the latter diagnosed as "tension headaches" by a neurologist.

TABLE 7.—Nervous System Problems (in 8 Patients)

Chronic Headaches	2
With Fainting	1
Sleeping Problems	3
Depression (by Zung Scale)	4
Scotoma	1
"Mental Fatigue"	1
Fear of Flying	2
Suspected in	2 or 3
Muscle Weakness (arm)	1

This woman described herself as "jittery" and "nervous" on the Cornell Medical Index. (This is a 4-page 195-question review-of-systems history form compiled by Cornell University School of Medicine in New York and available for less than 10 U.S. cents a copy.)

When depressive symptoms or thinking were suspected (in 4 patients), the Zung Depression Scale was administered. In each case, the patient checked out on the scale as moderately depressed, though the discussion that appends this scale points out that such might come in transitory states. Three of these patients apparently did have transitory depressive symptoms and recovered spontaneously. One patient, who had been suspended by her airline, later attempted suicide. This woman had also exhibited fear of flying during her air career.

"Jet Lag"

Long transmeridian flights, from Hawaii to as far as Bangkok and back, were the apparent cause of sleep disturbance in at least one woman.

This patient's symptoms actually became exacerbated in the months ensuing her house-

mate's death in the Samoa crash. She further complained of fatigue, scotoma, insomnia, "no energy," and had several respiratory infections in the year following the death of her friend.

On a Cornell Medical Index health questionnaire one year after the crash, she noted that she was a nervous person, nervousness ran in her family, and she answered "yes" to the questions, "Do you often shake and tremble?" and "Do sudden noises make you jump or shake badly?" A Zung Depression Scale on this patient was in the moderately depressive range at that time.

She was then transferred to the U.S. mainland. She phoned me on one of her stops in Honolulu about 1 year later and was still flying, apparently doing better, with improved sleep patterns and better general outlook.

Fear of Flying

A woman, who quit flying in late 1975 because she was finally able to admit to herself she was afraid to fly, was ill for 3 years from 1973 through 1975 while employed as a stewardess. She had been worked up for leukemia (lymphocytosis) by a hematologist in June, 1973, and was being treated for a "peptic ulcer" by another doctor when I first saw her in mid-1975. She also complained of sleep disturbance and was unable to eat on flights. She would often have to lie down during a flight because she felt so weak and sick. She also had intercurrent urinary tract infections and respiratory infections, and was incapacitated by seemingly incidental infections.

After several months of persistent gastrointestinal problems and weight loss, she was referred to a gastroenterologist who noted her foreign travel and "fairly atrocious dietary habits." No good reason for her symptoms was ever found, though fear of flying was suspected. This was discussed with the patient and she ultimately quit flying and went into an earth-bound job that required only occasional flights as a passenger from Hawaii to the U. S. mainland and back. Her symptoms subsided and she agreed fear of flying had been probably the major factor in her gastrointestinal and other symptomatology.

She was seen several times after she took an earthly job and was gaining weight. She still had viral respiratory and urinary tract infections, but they were not affecting her work. She had

TABLE 8.—Respiratory Tract—50 Cases

Upper:	34
nose	
sinuses	
ears	
pharynx	
Aerotitis	2
Nasal Obstruction	1
with rupture of ear drum	
Lower:	16
laryngo-tracheo-bronchitis	

likewise reported herself as a nervous person, "jumpy" and "jittery," with recurring frightening thoughts, on the Cornell Index. On the Zung Depression Scale while she was flying she ranked as "moderately depressed." She was not retested on this scale after she quit flying.

Respiratory tract illnesses, from sinusitis to tracheo-bronchitis with suspected pneumonitis, were present in 50 instances (Table 8). One stewardess, who came in with a bad cold, reported she had been "all over the Pacific in 5 days—up several nights without sleeping."

Gastrointestinal Problems

Despite travel to the tropics, diarrhea was rarely reported as a cause for sick leave in this group, except for a case of Shigella and the case mentioned earlier of fear of flying.

TABLE 9.—Gastrointestinal—10 Cases

Diarrhea	4
Shigella	1
Tropical Sprue (suspected)	1
Epigastric Discomfort	2
Constipation	1
"Functional" Problems ("nervous")	2

The Shigella diarrhea, was purportedly contracted in the New Delhi lay-over hotel dining room. Flight cabin attendants with proven Shigellosis are required to have 3 negative rectal swabs before they can resume flying and food handling.

Tropical sprue was suspected but not proven in one woman, who had previously been a Peace Corps worker in Southeast Asia. Functional indigestion and nervous stomach seemed to be a problem in several patients.

Genitourinary Disorders

Acute bacterial cystitis and monilia vaginitis were the most frequent problems in the genitourinary tract (Table 10). Pelvic inflammatory disease (PID) was diagnosed by me or a consulting gynecologist in 4 patients. One patient

TABLE 10.—Genitourinary—33 Cases

Cystitis (acute)	11
Vaginitis	17
Trichomonas	1
Herpes	2
Cervicitis	2
P. I. D. (Adnexitis)	4
Endometriosis (suspected)	1
Tubal Pregnancy with acute rupture	
(I. U. D. in place)	1

had a positive serum test for syphilis, remaining despite apparently adequate treatment several years earlier.

Urinary tract and gynecologic infections or problems kept some women on sick leave for prolonged periods. Gynecological problems, in-

cluding pelvic inflammatory disease, occurred in 23 instances. Some of the women went also to gynecologists, so not every case among this group was seen by me. One patient reported tubal pregnancy with rupture, with an IUD in place.

Six of the women had intrauterine devices for birth control, while 9 were on birth control pills. Several patients had neither or were not queried regarding birth control.

Musculoskeletal System

One stewardess experienced a foot injury without fracture, while she was home in Hawaii on leave (Table 11). The injury, in a ground job, would have kept her off the job for perhaps a day at most. As flight attendant, she was on sick leave for about one month, until she could stand and walk for several hours in high heels, as was required by her airline.

TABLE 11.—Musculoskeletal Cases

Muscle spasm	4
neck	2
back	1
anococcygeal (on duty)	1
Soft Tissue Injury of foot	
(while on leave)	1
Migratory Arthritis	1
Muscle Weakness	2
(a coffee spill—Neuropraxia)	
Lumbo-Sacral Disease	1

One patient (a nurse by training) had lumbosacral disc disease and underwent spinal fusion.

Miscellaneous Disorders

One 27-year-old woman had a thyroid nodule, which, at surgery, turned out to be a benign adenoma.

Mild anemia was noted in only 3 women. Of the 21 stewardesses seen, 15 were checked for hematocrit and/or hemoglobin, and 8 were checked more than once (Table 12).

TABLE 12.—Miscellaneous Disorders

"Cold" Nodule of Thyroid	
(Benign Adenoma)	1
"Weight Problem"	3
"Overweight" for Flight	2
Weight Loss ("can't eat")	1
Anemia (iron deficiency)	3
Positive Syphilis Test—	
previously treated	1

Blood Pressures were in the normal or low normal range (90/70 to 100/60) in most instances (one was 84/54). Only one patient had a diastolic as high as 90; she was a 29-year-old on birth control pills and her systolic pressure was 118. The other 2 highest readings were 118/86 in a 27-year-old woman and 118/78 in a 28-year-old.

No instances of heart or cardiovascular disorders or disease were seen.

The weights of these women (Table 13) were between 109 and 143 pounds (49.5 and 64.8 kilos). Two women told me they were too heavy by a pound or 2 to "weigh in" before a flight. One asked for a diuretic.

TABLE 13.—Weights-Heights

Weight Range—	
Lightest:	109 pounds or 49.5 kg.
Heaviest:	143 pounds or 64.8 kg.
Height Range—	
Shortest:	61 inches (5 ft. 1 in.) or 154.9 cm.
Tallest:	69.5 inches (5 ft. 9.5 in.) or 176 cm.

Table 14 shows requests for grounding which were initiated from my office, either at the patient's request or at my suggestion.

TABLE 14.—Requests for Grounding

1973	— 0
1974	— 1
1975	— 6
1976	— 2
1977	— 1

Summary

A sampling of health problems encountered by young women flight attendants seen in a Honolulu general practice is presented. This is by no means a complete survey of stewardess' health problems, but may give a notion of areas in which problems might occur. A survey of the medical literature over the past several years has turned up a dearth of articles on this rather important occupational area.

Recommendations

So that non-pilot air crews can work according to schedule with little time off for prolonged sick leave, it seems advisable to require robust healthy people to start with, without pre-existing disease and with a history of good recovery from previous infections.

Adequate rest periods between flight assignments would probably help to minimize sick leave for women flight attendants.

Entrance physical exams to include EKG, chest X-ray and standard blood counts and urinalysis and basic blood chemistries would seem minimal requirements for this type of work.

Some psychological testing might be helpful to determine any fear of flying and thus result in less lost work time or even termination of employment.



JOHN M. CORBOY, M.D.

Relative Morality

Last year there was much fuss when elections administrator Morris Takushi padded the timesheets of two state employees. They had threatened to quit because their pay (\$3.98 per hour) was too low, and Takushi admitted allowing them to falsify overtime to increase their pay to over \$6 per hour. After Lt. Governor King twice fired Takushi the matter made its way to the Civil Service Commission where, in a disturbing decision, the Commission found that falsifying records to "retain . . . valuable workers and to properly compensate them . . . was not only ingenious, but a way of life" in state government. "If Mr. Takushi is guilty," said the chairman, "the whole system is guilty."

Meanwhile a rural Oahu general practitioner, with a predominantly Medicaid practice, padded his claims to reflect additional patient visits which were not actually made. Since the state pays him 35 cents for each dollar of services, he felt it necessary to falsify the records to increase his income to cover costs, so that he could remain in business serving his indigent clientele. It wouldn't help the state or his patients for the doctor to go out of business. (Some might call this an ingenious way to "retain and properly compensate" a valuable worker!)

In both cases the law was broken: records were falsified to spend public money for what were rationalized as appropriate ends. Both men were admittedly guilty of fraud and deserved punishment.

But there the similarity ends. For padding the timesheets the public servant was exonerated as "ingenious" and reinstated, while for padding the daysheets the physician was ordered to make full restitution and spend thirty days in the clink.

There seems to be a problem of relative morality here. Cheating the taxpayers either way appears equally repugnant.

Don't Complain To Me

Our profession has a serious communications problem: we don't seem willing to talk about our concerns to the people who can help us.

The surgical dressing room fills with invective for legislators funding the Medicaid program, but it's "too far" (or "too late" or "too busy") to attend an evening meeting to confront these same legislators personally. The hospital cafeteria echoes with chatter over the blankety-blank chiropractors (or naturopaths or optometrists) but the complainers are seldom down at the capitol where their venom might do some good.

The phenomenon of bemoaning our problems among ourselves, while ignoring the most potentially influential sectors of the community is not unique to the medical profession. Other industries have suffered from similar short-sightedness. Recently some of our specialty groups have shown an inclination to abandon this useless practice by instituting political action committees and consumer education forums, to get their message over to the people. But we need a lot more public education.

Meanwhile don't complain to me about the Generic Drug Law or Worker's Compensation, until you've written a letter to the editor and volunteered your services to the specific HMA legislative committee. And quit carping over Patients' Rights or hospital privileges for nurse practitioners, until you've written everyone on the appropriate house and senate committees.

We've got to quit telling our troubles to each other, and start constructively talking and working with people who can do us some good. 'Organized medicine' really only consists of the bunch of us in the locker room, so we might as well put up or shut up.

Counterculture Therapy

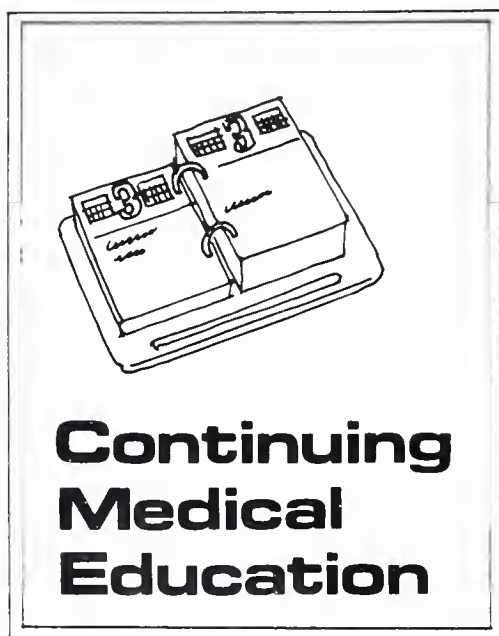
If you would learn of the groundswell of anti-science which flows beneath society's surface, tune to the healthing programs on the talk-radio stations.

You'll learn how some of your patients turn to *tarot* and rune stones and colonic irrigations. Palmistry and phrenology have returned, accompanied by iridology and *I Ching*. Bizarre diets and purges enjoy new popularity, and it seems generally accepted that fasting really will cure cancer (if you can keep it up long enough).

Drugs are out because they contain chemicals and possess side effects, while herbs and megavitamins-with-DNA are in, because they seemingly don't. Touching therapy, including massage and manipulation, remains popular, while the more masochistic attempt reconstruction through Rolfing. Through it all, one hears

talking: explanation and reassurance from the therapist, expression and ventilation from the patient. The therapeutic emphasis on wholism and naturalness continues, while the further from mainstream medicine the better.

There is something for us all to learn here. For the majority of patients who really are not organically sick, almost any 'medicine' will cure. Especially if it contains reassurance conveyed by word and touch, with a dash of kindly concern and a pleasant pinch of enthusiastic encouragement, flavored with a little magic, and free of unpleasant side effects. (It's scarce, so people happily pay a fancy price for it.) Probably not a bad idea to keep some of that stuff around the office.



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 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
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- F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
- G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m., Queens, Queen Emma Clinic.
- H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
 - B. Case Conferences, Tuesdays 10:00-11:30 a.m., Queens University Tower, Room 413 (Conference Room II).
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respiro, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Lectures
2. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
3. G. I. Conf., Third Tuesday, 8:00-9:00 a.m.
4. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Endocrine & Metabolism Conf., First, Second, & Third Wednesdays, 7:30-8:30 a.m.
6. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
7. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
8. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
9. Surgical Conf., First, Second, Third Fridays, 12:45-1:45 p.m.
10. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
11. Gynecology Departmental Mtg., Fourth Wednesday, 1:00-2:00 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective

2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
 2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
 3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
 4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
 5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
 6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
 7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
 8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. EENT Teaching Rnds., Tues. First 7:00 a.m.
3. Dept. of Med. Monthly Mtg. Second Tues. ea. mnth. 7:30 a.m. Sullivan 4-classroom.
4. Surgical Grnd. Rnds. Fridays (except Fourth), 7:30-8:30 a.m. Sullivan 4-classroom.
5. Surg. Mortality & Morbidity Conf. Fourth Fri., 7:30-8:30 a.m. Sullivan 4-Classroom.
6. Hematology Conf., Third Thurs. ea. mnth. 12:30-1:30 p.m. Sullivan 4-Classroom.
7. Renal Conf. First Monday ea. mnth. 7:30-8:30 a.m. Sullivan 4-Classroom.
8. Tumor Conf., ea. Monday, 7:30-8:30 a.m.
9. Pulmonary Conf. Second and Fourth Wed. ea. mnth. 12:30-1:30 p.m., Sullivan 4-classroom.
10. Endocrinology Conf. last Monday ea. month 12:30-1:30 p.m. UH-4 Classroom.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.

11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS

- Mar. 1-8, 1980 American Urological Assoc., Western Section. Am Urological Assoc. Inc., Box 1284, Sun Valley, ID 83353. King Kamehameha Htl., Kona (3/1-3/4); Sheraton Waikiki, Honolulu, (3/4-3/8).
- Mar. 1-8, 1980 Marquette-Med. Coll. of Wis. Med. Alumni Clinical Conf. MCW-8701 Watertown Plank Rd, Milw. Wis. 53226. Held on Maui.
- Mar. 10-15, 1980 Diagnostic Radiology including Ultrasound & CT Scanning, Duke Univ. Med. Centr, Box 3808, Durham, N.C. 27710. Held at Hyatt Regency, Waikiki. 30 hrs.
- Mar. 18-22, 1980 Sports Medicine, Depart. of Physiology, J.A. Burns Schl. of Med. 18 hrs. Cat. I. Held at Princess Kaiulani. Contact: Harold Brown, Hawaii Conf. Serv., P.O. Box 25055, Honolulu 96825 (808) 377-6445.
- Mar. 19-25, 1980 Traveling Medical Education Course, Penn. Med. Society, 20 Erford Rd., Lemoyne, PA 17043. 15 hrs. Cat. I. Held at Kauai Surf.
- Mar. 24-Apr. 4, 1980 Tutor Oncologist-Visiting Prof. Wm. A. Robinson, M.D. Med. Oncol. U of CO. For complete lecture sched. ph. (808) 531-1662, Kay VanSant, HI Div. Am Cancer Society.
- Mar. 27-Apr. 4, 1980 9th Obstetrical Anesthesia Conf. Ohio St. Univ. Coll. of Med. 410 W. 10th St., Rm N425, Columbus, OH. Held at Sheraton Waikiki, Honolulu.
- Mar. 31-Apr. 4, 1980 Current Concepts in Obstetrics and Gynecology, John A. Burns Schl. of Med. cosponsor- Univ. of Wash. Dept of OB-GYN & HI Section of ACOG. Held at Ilikai Htl, Honolulu. 24 hrs. Cat. I, 24 cognates ACOG.
- Mar. 29-Apr. 1, 1980 Infectious Disease Conf, Univ. of Wash. Schl. of Med. CME-E303 HSB, SC-50, Seattle, WA 98195. Held on Kauai 28 hrs. Cat. I.
- Apr. 12-19, 1980 Emergency Medicine, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Royal Lahaina, Maui. 30 hrs. Cat. I.
- Apr. 12-19, 1980 Diagnostic and Therapeutic Skills in Internal Medicine, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Mauna Kea Beach Htl., Hawaii. 30 hrs. Cat. I.
- Apr. 19-26, 1980 Orthopedic Review, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Mauna Kea Beach Htl., Hawaii. 30 hrs. Cat. I.
- Apr. 26-May 3, 1980 Management of the Surgical Patient, Stanford Univ. Schl. of Med., Stanford, CA 94305. Held at Mauna Kea Beach Htl., Hawaii. 25 hrs. Cat. I.
- Apr. 30-May 2, 1980 "The Patient and Transcultural Medicine," HI Regional Mtg. Assoc. of Military Surgeons of the US. Held at Tripler Army Med. Centr. Honolulu. Contact: COL S.A. Cucinell, Clinical Investigation Serv., Tripler AMC, HI 96859 (808) 433-6709.
- May 23-31, 1980 Diving Medicine, 1980 Update. John A. Burns Schl. of Med., Honolulu. Held at Kauai Surf Htl. 35 hrs. Cat. I.

May 3-11, 1980

California Soc. of Anesthesiologists, San Mateo, CA. Held at Intercontinental Htl., Maui, and Hyatt Regency, Waikiki.

May 10-17, 1980

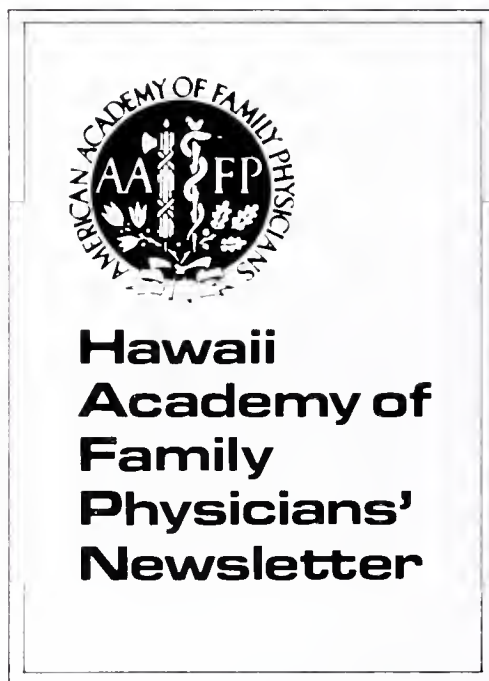
Pediatric Workshop, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Royal Lahaina, Maui. 30 hrs. Cat. I.

May 11-17, 1980

Modern Trends in Emergency Medicine, co-sponsored by National Emergency Services Inc.; HI Chapter of Emergency Physicians & John A. Burns Schl. of Med. CME Dept. (808) 947-8573 or (808) 948-7457.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



Our fondest Aloha and Mahalo went out to **Fred and Jean Reppun**, as they retired from their positions as Treasurer and Executive Secretary. Both of them have been such an important part of HAFF; it will be difficult to replace them and impossible to imitate that unique style with which they have carried out their many tasks, among them this newsletter, written by Fred for several years. Your new correspondents are not nearly as familiar with all the members and their activities, and we would appreciate your input on personal and professional matters for this newsletter. Please call 235-3115 with newsworthy items.

Hawaii Review, the Scientific Assembly, co-sponsored by HAFF and the British Columbia Chapter, College of Family Physicians Of Canada, concluded Feb. 4, and was judged to be a "huge success" by organizers and participants alike. This was the most ambitious program ever undertaken by our chapter, lasting four days and featuring eminent speakers from Hawaii, Canada and the mainland. Registrations numbered 356 (56 local), and the reception and Chinese banquet were attended by 520 M.D.'s and guests. Watch out USC!!!

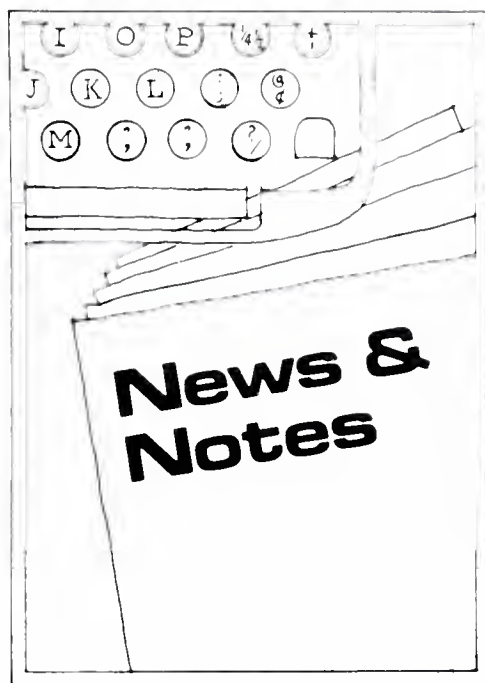
Our Canadian friends are planning to invite the Hawaii Chapter to their next meeting, held on Labor Day weekend in 1981. Start planning now! Also for your calendar, we are making plans for Hawaii Review II in spring of 1983. How's that for being on top of things?

Congratulations to all!

DON and MARLIES FARRELL



Am I Late?



HENRY N. YOKOYAMA, M.D.

Joe Nishimoto and **Allan Young** tied with net 68's for overall low net. Rather than a sudden death play off, they flipped coins and Joe won the prized TV set which he had promised tournament chairman **Ed Kagihara** for his waiting room . . . Ed later admiringly commented that Joe is truly an "intercourse champ" because he is a member of Waiālae CC,

Oahu CC and HICC . . . **Herb Takaki** won the "Hippopotamus Award" for high net and we must have been a close runner up (Can you believe a 9 on a par 4 without even going OB?) . . . Low gross was won by **Bill Yarborough** with a gross 80. A Flight winner was **Hideo Oshiro** who also shot a gross 80. **Don Maruyama** was 2nd, **Al Chun Hoon** was 3rd, **Glenn Kokame** 4th, **Paul Lin** 5th and **Masaru Koike** 6th. In B Flight, **Gabe Ma** was 1st, **Art Salcedo** 2nd, **Catalino Cachero** 3rd, **Winfred Chang** 4th and **L. Tien** 5th . . . **Manuel Abundo** was 6th and **Al Perez** and **Paul Tamura** tied for 7th. There was a C Flight, but we do not have the winners' names to date. **Phil Lee** was one of the winners . . .

Visiting Physician

Gene Stollerman, professor and chairman of Medicine at U of Tennessee, lectured at our local hospitals in February. Gene has been one of the most eloquent, spell-binding speakers we have heard in recent years. Herein are notes from his lectures:

"Streptococcal Disease and its Sequelae" (At KMC)

"Historically, there has been a changing pattern in streptococcal diseases . . . Before WWII, rheumatic fever was the primary cause of death among children and even during WWII, RF was extremely prevalent among our soldiers . . . But from the '50's and '60's, with the use of Bicillin, there has been a dramatic decline in streptococcal diseases and their sequelae, viz RF and AGN . . . Yet, the No. 1 cause of bacterial sore throats and skin infections is still the streptococcus . . . The advent of penicillin has made streptococcal disease seem of minor importance in our affluent communities, but 3/4 of the world still has a streptococcal reservoir . . . Fortunately we are on the eve of introducing an effective vaccine for streptococcus . . . We know now that nephritis and rheumatic fever never occur from the same streptococcal strain . . . Most of the strep strains you treat are not rheumatogenic . . . If you would only treat streptococcal infections properly (viz with penicillin) instead of with all the garbage (eg, Keflex at a dollar a capsule), we wouldn't be having any problems . . . Whenever housing and medicine is 'affluent' (Note: I did not say 'the best,' but 'affluent') the problem is the least . . ."

"Changing Spectrum of Bacterial Diseases"

"Bacterial transformation was first reported 30 years ago by Oswald Avery when he discovered that Type I Pneumococcus could be transformed to Type III . . . But he never got the Nobel Prize for this epochal discovery and he never will, because the Nobel Prize cannot be given posthumously . . .

"The genes are in constant agitation and toxins represent infected bacteria . . ." Re Changing Bacterial Genomes: a. Mutation: spontaneous or induced b. Transformation: uptake of DNA c. Transduction: bacteriophage transmission of DNA d. Conjugation: sexual transmission; plasmid transfer; extrachromosomal DNA (The most common form is conjugation . . . There is sex in bacteria too . . . Plasmid transfer sexually . . .) This is my favorite X-rated picture (As he showed a slide of two E-Coli in sexual conjugation with plasmid transfer).

Re Antibacterial agents interfering with: 1. Cell Wall Synthesis: eg, penicillin, cephalosporins, vancomycin, bacitracin; 2. Membrane Permeability: eg, amphotericin B, polymyxin, nystatin; 3. DNA, RNA—Genetic Process: eg, nalidixic acid, rifampin, novobiocin, oxolinic acid, adenine phosphamide, novobiocin; 4. Metabolic Process: eg, sulfonamides, trimethoprim; 5. Ribosomes—Protein Synthesis: eg, aminoglycosides, spectinomycin, tetracycline, chloroamphenicol, erythrocine, clindamycin.

"Let me talk about my favorite bacteria viz the gonococcus . . . I have the right to talk about the ones I want . . . With its pilae, the gonococcus is the stickiest bug I know . . . Someone gets gonococcus pharyngitis because he is doing something he shouldn't. I started giving procaine penicillin in 1941 . . . One shot was effective against GNC and syphilis . . . I've never seen gonococcal polyarthrititis resistant to penicillin . . . I would bet the house staff 2 martinis a day for a week on this truism (One can easily become an alcoholic with this cinch bet) . . . Another sexy picture I have is this (A slide showing a human sperm with half a dozen gonococci sticking to its tail . . . and ready to enter an oviduct) 10% of males have no urethritis symptoms . . . Diagnosis can only be made by culturing the meatus . . . They transmit the GNC to females who develop gonococcal arthritis . . . A penicillinase producing GNC was discovered in Manila . . . This strain traveled to Travers AFB via the urogenital tract . . . Fortunately their occurrence is rare and there have been only a few isolates in the US and in England . . . Treatment is with Spectinomycin . . .

"Pneumococcus Type 19 came from the Children's Pneumonia Service in Johannesburg . . . It was resistant to everything . . . So the pneumococcal vaccine was developed in 1946. Resistant staphylococcus . . . Respond to Gentamicin only . . . Organisms of bacterial endocarditis: We need bacteriocidal rather than bacteriostatic agents.

"Group A Streptococcus: Dr. Miyamoto's group in Japan reported in 1978 that they had isolated a Type 12 strain which is 70% penicillin resistant, 90% tetracycline resistant and 66% chloromycetin resistant. (It's enough to make me swallow a whole package of Tums.) The reason is that antibiotics are sold over the counter and the patients are taking broad-spectrum antibiotics . . . So we do need a streptococcal vaccine . . .

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"I hope I have scared you . . . that I have worried you . . . Doctors are stubborn . . . When I tell a neurosurgeon not to use prophylactic antibiotics, he'll tell me where to go . . . I can plead for a short time . . . And you can at least go back and cancel the antibiotic order within 24 hours . . . Don't use new antibiotics that the detail men push . . . If the cephalosporins disappeared tomorrow, I'll never miss them . . .

"Rheumatic Fever is the disease that licks the joints and bites the heart . . . Disease changes are so fast that it takes the breath away . . . I wrote this book, 'Rheumatic Fever and Streptococcal Infections' in 1975 . . . It won't send my kids through school because people don't read anymore. Each chapter is a labor of love and contains 1100 references . . .

"In this affluent world, we've had spectacular changes in the streptococcus since 1956. At the Great Lakes Naval Station, I started giving 30 to 35 thousand units of Bicillin to every recruit since 1958 and now I can't get the Navy to stop . . . They gave me a medal for wiping out rheumatic fever and another for wiping out syphilis . . . And yet another for wiping out meningococcal meningitis . . .

"Strains of streptococci that cause nephritis do not cause RF . . . In Chicago, RF decreased in Summer (July-Sep.) while pyoderma and nephritis increased and in Fall (Oct.-Nov.), RF increased and AGN decreased . . . Skin infections do not cause RF . . ."

Re Streptococcus Vaccine: Pep M 24 . . . The M protein on the streptococcus capsule is obtained by gently washing the hair off (ie, giving a shampoo rather than a haircut) . . . "I must say that these days, to introduce a vaccine, one needs a strong will . . . We need a spirit of volunteerism . . . The lawyers have made vaccine a nightmare . . . The pharmaceutical companies won't touch vaccines . . . because of some idiot judge . . . We've made a nightmare for the pharmaceutical companies . . . Who needs the vaccine? When resistant streptococcal strains appear esp. in those areas of the world where streptococcal reservoirs remain (viz 2/3 of the world) Our population doesn't understand vaccines . . . For example, we know that Guillain Barre occurs naturally and was not necessarily because of the Swine Flu vaccine . . ." (Ed: We realize our notes were fragmentary, but we were held so impressed by the magnificent eloquence of this man, Gene Stollerman, that we tried to recapture in writing some of his spirited dogmatism . . . It is a truly enlightening experience . . .)

Life In These Parts

Spanking new green Mazda RX 7 in the doctors' parking lot at QMC . . . License plate reads "PHOTON" . . . Must be a nuclear med man . . .

A fishy tale? **Ed Yamada** relates how the medical resident at KMC thought it was funny that the two patients admitted on team care that day were named Aku and Mahi . . . Ed. found it even more humorous because the resident's name was Ono . . .

"Wayne Newton is in town and, because of friends **Dr. and Mrs. Walter Ching**, has agreed to do a benefit concert for

Kapiolani Children's Hospital sometime in Oct. . . ." (*Advertiser* columnist Don Chapman . . .)

Carl Lehman, Straub allergist, made the following interesting observations on asthma in Hawaii: June or July are the least bothersome for asthmatics . . . When the house dust mite dies, its remains mix with house dust and become a main cause of allergies . . . The mite increases with higher humidity so during June and July when it's drier and hotter, we have fewer of these mites . . . Milk, eggs, yeast, wheat and corn products are often troublesome . . . Shrimp, lobster, citrus fruits and tomatoes also cause problems . . .

The medical community owes a big vote of thanks to the Chamber of Commerce of Hawaii and those administering its Public Health Fund. Last year they provided \$13,000 so that the weekly HMA television series "Your Body, Your Mind" could be produced for 1 year. Again this year, they have approved an \$8,900 grant to the Hawaii Section, American College of Obstetricians and Gynecologists to develop a drug and pregnancy information center within the Poison Information Center at Kapiolani Children's Center. The Chamber has served as trustee of the Public Health Fund since 1914 when the fund was created by Honolulu shipping agents in 1899 to help the Board of Health combat an epidemic of bubonic plague . . .

While the January storms lashed the islands again and caused damage in the millions, at least 5 persons were killed . . . One of them was **James Erickson**, 47, of Waimea who was with the Hawaii Emergency Physicians . . . Jim and his wife were driving on the old Waimea Highway to Kona when he stopped to pick up firewood and a tree fell on him . . . Hana, Maui had its power knocked out by the storm and **Milton Howell** delivered two blackout babies at Hana Hospital, one of them his own grandchild . . . It seems that a Sheraton exec was getting a physical exam from **David Eith** when the lights went out . . . The exec asked if the blackout meant that his procto exam was out and the good doctor replied, "Yes, unless you want me to put a candle on the end of it." (Excerpt from Dave Donnelly's Hawaii)

The Hawaii Medical Association spent \$8,580.00 in lobbyist expenditures in 1979 as compared to \$29,761.30 spent by the oil interests, \$18,595.01 by business interests, \$11,617.68 by resort interests and \$10,813.64 by The People (Common Cause). We fared better than financial interests which spent \$8,037.27, agriculture with \$4,129.57 and unions with \$2,423.67 . . .

Denis Mee-Lee, chief of the Mental Health Division says, "The Hawaii State Hospital is faced with a critical space and staffing problem because the mood of the community is to lock people up and away. Everybody is kind of playing it more cautiously and responding to the public concern issue."

It seems that 1980 will be a bad year for sunbathers . . . **Curtice Martin**, dermatologist at Fronk Clinic in Pearlridge feels that the predicted increased sunspot activity will make 1980 "a super bad year for sunbathing especially between the hours of 10 and 2."

"The sunspots are coming! The sunspots are coming! The doctors and the astronomers are trumpeting these days—the



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astronomers with delight and the doctors with dismay . . ." The astronomers are happy because 1980 will be the year with the most sunspots in this century and the doctors are warning that 1982 or 83 will be the year of the melanoma . . . Dermatologists **Norman Goldstein** and **Sam Allison** say that medical studies have shown that the number of malignant melanomas in the U.S. has been increasing during the past 40 years with peaks that closely follow sunspot cycle peaks.

Katsuhiko Yano, associate director of the Honolulu Heart Study at Kuakini Hospital since 1965 says that moderate drinking (4½ cans of beer a day) apparently reduces the chances of coronary heart disease, but he doesn't recommend drinking for longevity because of increased rates of other diseases eg, cancer, strokes, cirrhosis, etc. Katsuhiko also claims that Japanese men in Hawaii are probably the healthiest group in the world and thus their study should provide valuable information for improvement in man's longevity . .

Hors De Combat

Back around Christmas last year, there appeared a short item in the *Advertiser* that the State attorney general was looking into the fee payment schedule of the HMSA to see whether there may be any violation of local antitrust laws. Consumer Protector Stanley Suvat said that the investigation was a spinoff of what is happening at the federal level where the FTC has been looking into the handling of doctors' payments by Blue Cross/Blue Shield on the mainland. The question involved the usual or customary fee payments. Suvat noted that "by setting standardized fees, the plans may in effect be price fixing . . . It is unclear whether the fee schedules used by HMSA would fall under the limited exemption from local anti-trust laws . . ." (Ed. . . . Wonder what happened to this investigation?)

The national director for HEW's EMS division, David Boyd feels that implementation of a statewide EMS system for Hawaii is about 3 years away. Oahu already has a fully im-

plemented EMS system, but the Neighbor Islands still lack the administrative system and Boyd estimates that they will need about \$400,000 a year over 3 years before the system is operational. He feels that Oahu's EMS system is one of the five best programs in the country . . .

Physicians Speak Up

Herein are excerpts from **O. D. Pinkerton's** letter to the editor re Medicaid: "Our Legislature decided to curtail state costs by ripping off the physicians—they being without a union and traditionally known to care for the poor as well as the wealthy without favoritism. We have done this and the Legislature responded by ordering that fees be kept at 75 percent of 1975 fees. We now learn that state coffers are overflowing with millions of tax dollars in surplus . . . The latest news is that the 'take' in state taxes in December 1979 was over \$2 million more than in December 1978 . . . Many physicians are refusing to participate in this program because of the horrendous increasing cost of doing business over the past five years. Should the number of physicians be reduced to 50 percent or less, the federal money will cease because federal support requires that half the physicians participate. The state will then be responsible for the entire bill for medical welfare . . . It is legalized cheating by the state on a very important segment of society, viz the medical profession."

John Corboy also wrote: "Our state has an apparent surplus and the Legislature will examine options for reimbursing the taxpayers . . . Last year under an amendment to the Medicaid Law, the Legislature decided not to reimburse physicians at the 75th percentile of the 1978 DSSH fee scales, but cut payments back to the 1975 level. (Ed: This meant that the compensation actually dropped to about 35 percent of current costs, instead of the agreed 75 percent) . . . Many physicians simply stopped seeing Medicaid patients. Others continue underwriting the program, receiving about 35 cents on the dollar. This means that of three Medicaid patients,

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The technical training of physicians in the detection, diagnosis, and management of melanoma is the primary focus of program efforts. Education of the public and the training of health and allied professionals is a corollary to physician training, and will be pursued at a later time.

Your support of this program is requested and your suggestions are most welcome. Your attendance at the training programs presented through the HMA and other organizations will be greatly appreciated by the people of Hawaii — your patients.

For further information call 548-8422, or write Director, Community Cancer Program of Hawaii, 1236 Lauhala Street, Honolulu, Hawaii 96813.

physicians are paid for one and see the other two 'for free,' while the state declares a surplus! Before counting a surplus or asking paying patients for subsidies, the state must assume its fair share. First, the fee schedule must be brought back up to the 75th percentile of the current annual profile. (The state has protested that this might cost \$20 million, which simply reveals the amount Hawaii's physicians and their patients donated to the program last year!) Next, realistic Medicaid funding must be established and maintained . . . Medicaid funding remains a federal-state responsibility . . . Federal support of Hawaii's Medicaid program requires that half the physicians participate. If the Legislature does not heed its responsibility, physician support will soon fall below the required 51 percent, and federal funding will automatically cease . . ."

Re the Bill for Unionization of Interns . . . **Walter Young** explained, "The IRS, which is interested in collecting money, has ruled that interns are employees and thus their stipends are taxable. However, the National Labor Relations Board has ruled them to be students and thus may not form a union. Attempts to resolve this in the courts resulted in the opinion that the government does not have to be consistent in its rulings. This dual standard was the reason for the bill being introduced in Congress."

From **Jack Scaff** and **John Wagner's** comments on "Jogging and good Health" . . . Jack and John are critical of *Advertiser* columnist Don Chapman's comments "equating jogging and guns." They wrote: "Jogging doesn't kill . . . Heart disease does and all the worse if undiagnosed and unrecognized . . . This conclusion is substantiated by Professor Ernst Jokl, one of our century's outstanding physician exercise physiologists who summarized his exhaustive book, 'Exercise and Cardiac Death' by stating: 'Not one instance was encountered in which death could be regarded as due to the effects of extreme exertion on a previously healthy heart.'"

"We concur with Don that exercise should not be suggested as a panacea for all ills or be approached without appropriate evaluation as determined on an individual basis . . . As you know, we have recommended publicly on innumerable occasions that clearance for exercise includes a treadmill stress test for all individuals over the age of 35 and also that this proviso be extended to those other individuals with a history of significant cardiovascular risk factors or cigarette smoking.

"Item—The Central YMCA has one of the largest cardiac rehabilitation programs in the nation . . . Since its inception in 1973 there have been literally hundreds of thousands of supervised patient hours of exercise and all in individuals with cardiovascular disease deemed so serious that the referring physician considered exercise in the unsupervised state to be hazardous. Result—There has not been a single fatal cardiac event during class in the past 7 years.

"Item—The Honolulu Marathon Clinic, sponsored by the Dept. of Parks and Recreation, has trained over 12,000 beginning runners since 1974. There have been three major cardiac events during the time, each occurring in an improperly screened individual who knowingly entered the program in spite of medical advice to the contrary.

"Item—During the past six years nearly 200 cardiac patients have successfully completed the cardiovascular division of the Honolulu Marathon without a single incidence of a significant medical problem during their participation.

"Item—More people engage in running/jogging than in any other single sport, yet all other sports have a higher mortality.

"Item—Hawaii has more joggers per capita than any other state in the nation by a factor of 10 or 20 to one, accounting for several hundred thousand hours of jogging weekly. Cardiac events have been so infrequent during jogging as to be newsworthy.

"Media reports to the contrary, we continue to be unaware of any individual meeting these criteria either locally or nationally who has collapsed and died of a cardiac event while jogging.

"It is obvious then that the most dangerous form of exercise is watching. While one must be in perfect health in order

to be sedentary, all sorts of individuals with various degrees of disability have successfully completed the Honolulu Marathon.

"Taken in perspective, that is a cardiac rehabilitation program for people with heart disease, a marathon clinic for beginners and on your own if you know what you are doing, it is clear that jogging is the safest form of exercise there is."

Our "Angels"

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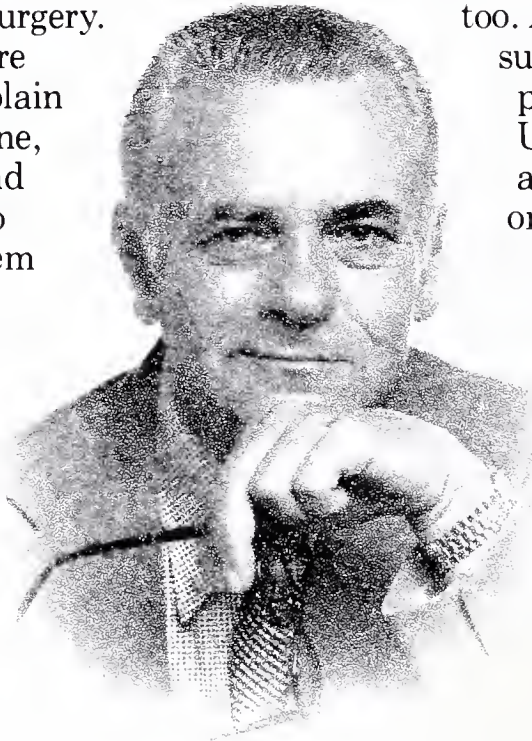
To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

about these important matters.

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HMSA Utilization Review Department

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MARCH, 1980
VOL. 39, NO. 3

Hawaii Medical Journal

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Subdural Hematoma and Cerebral Infarction (Non-Hemorrhagic): Relative Efficacy of Computerized Tomography and Brain Scanning in Their Detection

RAYMOND T. CHUNG,* *Honolulu*

● *In separate studies conducted at Straub Clinic on 59 patients with suspected subdural hematoma (SDH) and 60 patients with non-hemorrhagic cerebral infarct (CI) who had computerized cranial transmission tomography (CCT), radionuclide brain scanning (RBS, or a combination of both, it was found that CCT is more sensitive for both lesions initially, eventually declining, while RBS, though less sensitive early, detects older lesions more reliably. The data suggest, therefore, that complementary utilization of the two diagnostic techniques is often essential in the workup of potential SDH and CI.*

Before the advent of computerized tomography, the only noninvasive diagnostic technique for cerebral abnormalities was radionuclide scanning (introduced in 1963).¹ The radionuclide brain scan (RBS) produces an "indirect" image of the brain, with the organ as a "cold" area supplied by "hot" vessels and surrounded by a "warm" envelope. Ability to detect disease is dependent upon either significant vascular change or a breakdown in the so-called blood-brain barrier. In spite of its limited visualization of anatomical detail, RBS has proved effective in diagnosing focal lesions, with sensitivity rates reported near 85%.² Concomitant blood flow studies (introduced in 1964) provide additional insight into vascular obstructions.³

Like RBS, computerized cranial transmission tomography (CCT) is a noninvasive procedure for the study of central nervous system disorders.⁴ Unlike its nuclear counterpart, however,

this new method (introduced in 1973) permits virtually direct observation of cerebral anatomy by computer analysis of x-ray absorption. It is especially valued for its ability to reveal the subtlest of density differences. With the added element of intravenous contrast enhancement, the CCT method can produce images with even greater detail.

CCT, its diagnostic virtues notwithstanding, has created a furor over its high price tag (approximately \$500,000 purchase, \$30,000 per year in mechanical costs).⁵ Critics label it a major contributor to the rising cost of medical care. In reality, CCT is far less expensive than angiography, pneumoencephalography, myelography, and burr hole incision, which are also more risky, uncomfortable, and time-consuming invasive diagnostic modalities requiring hospitalization. Whereas a standard outpatient CCT scan for subdural hematoma costs approximately \$250 (RBS about the same), the previously routine angiogram, attendant costs included, runs an average of \$1,500. CCT and RBS are both invaluable assets to the diagnostic physician, for they comprise the most accurate noninvasive techniques available. The key issue then becomes the relative efficacy of the two tests in diagnosing sundry cerebral afflictions.

Because of its inherently high resolution, CCT is superior in the detection of most primary neoplasms (especially low grade), hydrocephalus, intracerebral hemorrhage, cerebral injury, and hemorrhagic infarct. RBS appears to have greater success diagnosing posterior fossa tumors, metastatic lesions, and inflammatory processes. Arteriovenous malformations are

*Summer Scholar, Pacific Health Research Institute.

Reprint Requests to: Fred I. Gilbert, Jr., M.D., 888 South King Street, Honolulu, Hawaii 96813.

Accepted for publication, August, 1979.

readily visualized by both methods. It would seem, then, for these conditions, the physician's route would be clearcut. However, there are two fairly common lesions—subdural hematoma and cerebral infarct—that often escape detection on either scan. Fordham¹ and Alderson *et al*⁶ conclude that a correlation exists between RBS and CCT sensitivity and time after onset of neurologic deficit for both SDH and CI. Specifically, RBS, initially low in sensitivity, increases its detection rate with time, while CCT sensitivity starts high, then declines for some days, and finally heightens.

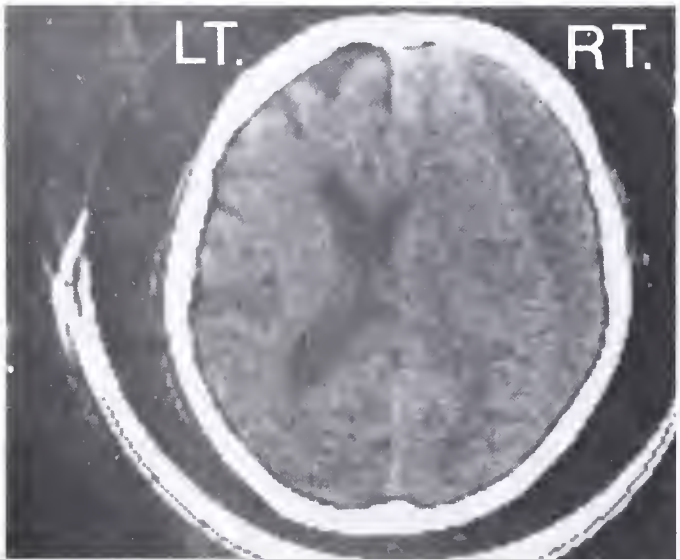
In order to assess the validity of such conclusions, retrospective analysis of patients suspected of the two conditions was conducted over two summers (1978 and 1979) at Straub Clinic and Hospital.

Subdural Hematoma

Subdural hematoma (SDH) is a fairly common disorder which is sometimes difficult to diagnose. It is defined as an accumulation of blood between the dura and arachnoid, usually after head trauma. Untreated, the hematoma can lead to impairment of motor, sensory, respiratory, and cardiac function, and ultimately, death. However, if the mass is properly visualized and removed, prognosis is excellent. Clearly, diagnosis is the key, and CCT and RBS fit prominently into the clinical picture; just how they fit is the purpose of this study. A few illustrative examples of how each of today's sophisticated diagnostic techniques visualize this lesion are presented in Figs. 1-5.

The first 34 patients had CCT workup at Queen's Medical Center (EMI Mark I, intro. 1/76), while the remainder (25) were covered by the new Straub unit (EMI CT 1010, intro. 9/78).

FIG. 1.—Computerized cranial tomography without intravenous contrast enhancement reveals a significant right-sided lucency consistent with chronic subdural hematoma. This low-density lesion contrasts sharply with surrounding higher-density brain tissue. Note also the concomitant shift of the ventricles and the effacement of right-sided sulci.



Aside from age of equipment, there are no significant technical differences between the two. All nuclear brain imaging was performed at Straub with conjunctive blood flow studies. In all cases, baseline diagnosis was established either surgically or angiographically. If one is to consider the Straub and Queen's CCT data combined, the results are confirmatory. For newly formed or acute subdural hematoma (1-3 days after onset), CCT is 100% sensitive (Table 1, Fig. 6), probably because early in the course of the hematoma, the highly dense extravasated blood

FIG. 2.—Static radionuclide image of same patient also clearly visualizes the hematoma as a very broad swath of increased activity on the right.



FIG. 3.—Conjunctive dynamic blood flow image shows a pocket of decreased blood flow especially in the upper right half of the hemisphere.

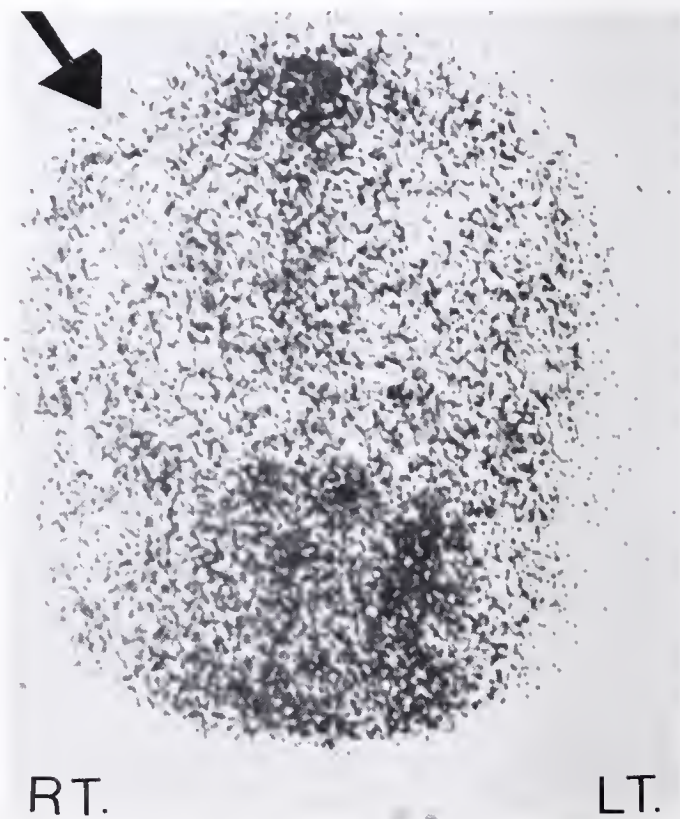


FIG. 4.—Quantitative analysis of the blood flow study by computer confirms the decreased flow to the right hemisphere in contrast to the left.

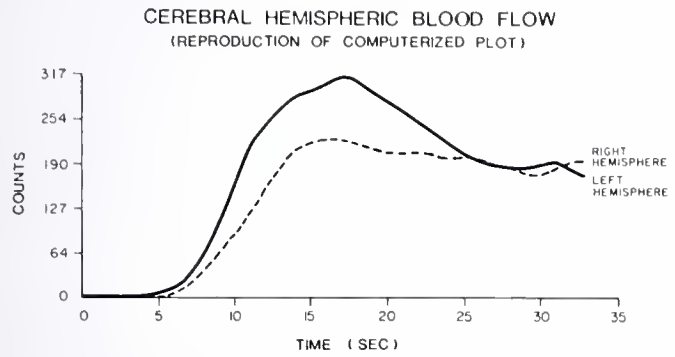
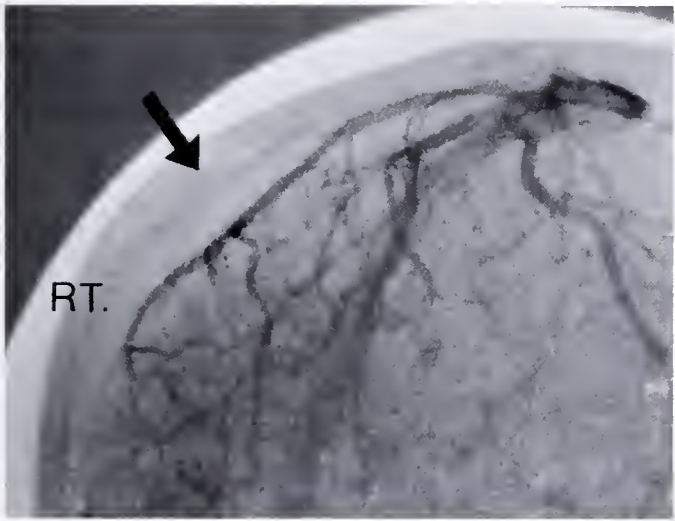


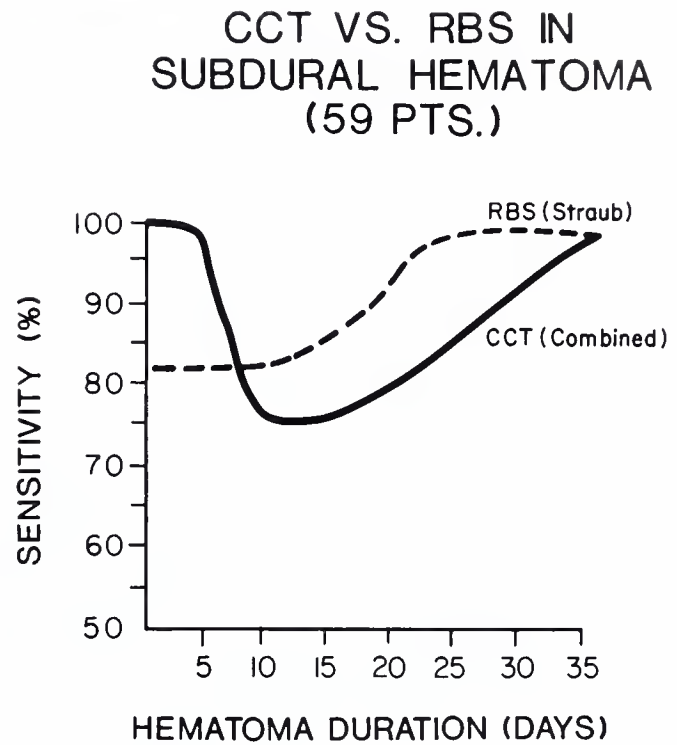
FIG. 5.—Selective cerebral angiography on another patient demonstrates avascular right mid and upper convexity mantle separating the cortical vasculature from the underlying meningeal vessels compatible with subdural hematoma. The neuroradiologist must rely on indirect mass effect evidence to make the finding.



contrasts sharply with the adjacent brain. RBS, however, in the absence of a reactive membrane, will sometimes miss a freshly formed hematoma.⁷

As the blood accumulation ages, it is drained of its high-density constituents and, Davis⁸ postulates, becomes isodense with the brain. The effect on computerized scans is unfavorable. In light of this reduced density differential, the radiologist is more dependent on contrast enhancement and mass effects in making the diagnosis. Nonetheless, sensitivity is a somewhat di-

FIG. 6.—CCT appears superior in the first week after onset of hematoma, after which RBS detects the lesion with greater frequency. Both perform highly effectively at about 35 days and presumably beyond. Sensitivity reflects rate of True Positives in confirmed subdural hematomas.



minished 75%. RBS, conversely, begins picking up more and more of these subacute subdurals (approximately 1-3 weeks duration) as the blood-brain barrier undergoes further deterioration. The hematoma attains the chronic stage (over 3 weeks) when two processes occur: first, when it develops an enveloping subdural membrane, and second, when its density drops below that of the brain. Correspondingly, both scans increase in sensitivity, RBS to 100%, CCT to 93%. On the whole, nuclear scanning is slightly more sensitive than CCT, 92% to 88% (Queen's 79%; Straub 100%). (NOTE: There were many more chronic cases, so overall sensitivity may be less indicative of efficacy.)

CCT is much more specific, correctly identifying 100% true negatives to RBS's 79%. A probable explanation for this disparity in specificity is the relative facility with which external soft tissue injury can mimic a subdural space-

TABLE 1.—CCT vs. RBS in Subdural Hematoma

DURATION OF HEMATOMA	SENSITIVITY(%)		SPECIFICITY(%)		ACCURACY(%)	
	RBS	CCT	RBS	CCT	RBS	CCT
Acute (App. 1-3 days)	100(1/1)	100(2/2)				
Subacute (App. 3-21 days)	82(9/11)	75(6/8)	79(11/14)	100(19/19)	87(33/38)	93(40/43)
Chronic (over 21 days)	100(12/12)	93(13/14)				
Total	92(22/24)	88(21/24)	79(11/14)	100(19/19)	87(33/38)	93(40/43)
Double Scans						
	CCT+ RBS+	CCT- RBS+	CCT+ RBS-	CCT- RBS-		
No of Pts.	11	3	1	1		
Total:	15/16, 94% Combined Sensitivity					

occupying effect on RBS.⁹ CCT, however, is capable of making this differential diagnosis.

Overall, because of its higher detail of structures, CCT has a higher accuracy (sensitivity and specificity combined) than RBS, 93% to 87%. Since the inception of CCT at Straub, only one in 25 suspected subdurals went to selective cerebral angiography, where previously all such patients underwent this significantly risky procedure.

Based on the cited data, the following recommendations can be made as to the employment of CCT and RBS for subdural hematoma. If the clinician has a strong suspicion of SDH and can be confident of the duration of the lesion, then the initial diagnostic choice should be that which has the correspondingly higher sensitivity. (A graphic display such as Fig. 6 would prove especially helpful.) If suspicions are confirmed, then the diagnosis may be established and appropriate therapeutic measures taken. The other test would be mandatory if the first should produce equivocal or negative findings. However, if both scans yield no abnormalities and the patient continues to present with pathognomonic symptoms, then angiography may be unavoidable. Given our figures, though, this would be a rare occurrence indeed.

If there is only mild suspicion, the same initial protocol is in order. However, if findings are positive and CCT is performed first, RBS need not be utilized, owing to CCT's high specificity. But if RBS is the initial modality, CCT should be taken to rule out the false positive. Any conflict should be resolved by angiography. If the initial finding is negative, then the clinician can be fairly confident in ruling out subdural hematoma. Where before, angiography was performed on all suspected SDH's, now CCT and RBS are the diagnostic rule, thereby saving thousands in cost. The benefit of the two techniques in subdural hematoma is especially evident.

These figures are not by any means invariant. After all, researchers may differ as to what constitutes a "true positive" or a "false negative" scan. This report considers the detection of a correctly localized intracranial abnormality as a true positive even if the definitive diagnosis can

not be ascertained. False negatives will reveal no defects in the region of interest.

It is also possible that there may be insufficient patient numbers to justify such conclusions. However, the results appear compatible with those in print. Any discrepancies in the data (especially overall sensitivity) between the Straub and Queen's EMI scanners can be ascribed to quality of scan print, age difference of hardware, interpretive differences or variations in patients' problems.

Cerebral Infarct

The second major area of concern was that of cerebral infarct (CI) of the thrombotic variety: death or destruction of brain tissue due to a clot in an artery, usually accompanied by arteriosclerosis. Prior to RBS and CCT, angiography was the only modality of accuracy for CI. Now with two noninvasive procedures, such a risky diagnostic workup can be all but avoided. In the final analysis, both scanners behave for infarct as they do for subdural hematoma. For this phase of the study, the final clinical diagnosis served as the baseline, because stroke treatment does not involve surgery.

In the first two days after onset of suspected stroke, the nuclear scanner has a poor true positive rate, while about two weeks post-infarct, its sensitivity approaches a peak 80% before tailing off to non-visibility. The pathophysiologic correlation here may be that there is an inherent lag in metabolic decline following stroke—hence the delay in radionuclide pickup. In contrast, CCT (data from Queen's only) follows a steady downward temporal pace, commencing near 75% and dwindling to 55% after 3 weeks. (See Table 2, Fig. 7). However, it is markedly superior to RBS in detecting old infarcts. (The RBS *flow studies* may reveal cerebral artery occlusion with or without associated infarcts, indefinitely.) This would seem logical when one considers that while the anatomic changes in infarct are permanent, the chemical processes are ever mending. Thus, an old lesion will evade visualization on RBS once the blood-brain barrier is restored. Overall, CCT produces roughly 63% true positives, while RBS

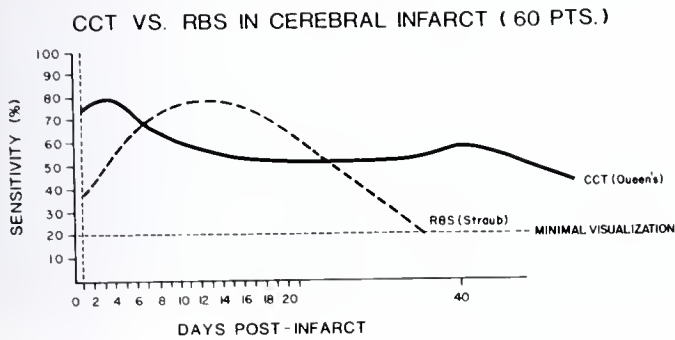
TABLE 2.—CCT vs. RBS in Cerebral Infarct

DAYS POST-ICTUS	SENSITIVITY(%)		SPECIFICITY(%)		ACCURACY(%)	
	RBS	CCT	RBS	CCT	RBS	CCT
0-2	44(8/19)	57(4/7)				
2-7	53(10/19)	77(10/13)	100(2/2)	100(4/4)	52(25/48)	72(26/36)
7-21	71(5/7)	71(5/7)				
Over 21	0(0/1)	60(3/5)				
Total	50(23/46)	63(22/32)	100(2/2)	100(4/4)	52(25/48)	72(26/36)

No. of Pts.	Double Scans				(+) True Positive (-) False Negative
	CCT+	CCT-	CCT+	CCT-	
	RBS+	RBS+	RBS-	RBS-	
Total:	13	1	8	7	
	22/29, 76% Combined Sensitivity				

hovers at 50% sensitivity. In patients where both scans were employed, however, diagnosis was made 76% of the time, suggesting that a combined approach to the problem may be the best one.

FIG. 7.—The two points of transition correspond to roughly 6 and 24 days. Before and after, CCT should be the initial diagnostic choice, while in between, RBS is the more sensitive test. After about 40 days, CCT should be employed almost exclusively, for RBS will no longer pick up infarct with any degree of accuracy. 20% sensitivity represents the lower limit of scan visualization.



If the patient presents with positive symptoms, the clinician may order both scans routinely, due to the high percentage of misses for each procedure; the initial choice is again dependent on the stage of the infarct. If one or more yields a positive finding, the diagnosis of CI may be entered. If both scans produce negative results and all other tests (i.e., EEG, OPG-CPA, angiography if clinically indicated) also prove negative, then the infarct, if any, may be deemed small, with an excellent prognosis.

In fact, it was discovered that both scans consistently fail to visualize small, deeply placed strokes, which are known to cause very minimal

long-term deficit. Thus, the seemingly low combined sensitivity rate may be considered quite high, for these lacunar infarcts have relatively minor pathology. This, of course, also dictates a limit to the size of the lesion. The diagnostic radiologist must be sure to employ intravenous contrast enhancement wherever possible in CCT scanning, for the high incidence of isodensity has been documented for infarct.¹⁰

As in subdural hematoma, angiograms performed for cerebral infarct have been significantly reduced by the presence of the two new methods without compromising the quality of diagnostic workup, testimony to the progress in medical technology.

Summary

By delineating the intricate temporal dependence of the two techniques, it becomes unerringly clear that CCT and RBS are not competitive but complementary procedures, which both deserve appropriate utilization in subdural hematoma and cerebral infarct workup. And by reducing significantly the need for invasive and expensive angiography, CCT and RBS prove their worth not only to physician and patient, but also to the cost-conscious public.

Acknowledgement

The author is indebted to Fred I. Gilbert Jr., M.D. and Michael J. McCabe, M.D. for their invaluable consultative assistance and to Mavis Ke for her secretarial assistance.

REFERENCES

1. Fordham EW: The complementary role of computerized axial transmission tomography and radionuclide imaging of the brain. *Semin Nucl Med* 2:137, 1977.
2. O'Mara RE, Mozley LM: Current status of brain scanning. *Semin Nucl Med* 1:7, 1971.
3. Harper PV, Fink RA, Beck RN, et al: Rapid brain scanning with 99m Technetium, VII Symposium Neuro Radiologicum, New York, 20-25 Sept. 1964.
4. Hounsfield GN: Computerized transverse axial scanning: Description of system. *Br J Radiol* 46:1016-1022, 1973.
5. Hawaii State Health Planning and Development Agency. Annual Report. 1978-79.
6. Alderson PO, Gado MH, Siegel BA: Computerized cranial tomography and radionuclide imaging in detection of intracranial mass lesions. *Semin Nucl Med* 2:111, 1977.
7. Cowan RJ, Maynard CD, Lassiter KR: 99m Technetium per-technetate brain scans in detection of subdural hematoma: Study of age of lesion as related to development of positive scan. *J Neurosurg* 32:30, 1970.
8. Davis PO, Pressman BD: Computerized tomography of the brain. *Radiol Clin N Am* 12:297, 1974.
9. Gilday DL, Coates G, Goldenberg D: Subdural hematoma: What is the role of brain scanning in its diagnosis? *J Nucl Med* 14:283, 1973.
10. Pollock JA: Stroke. In *Computed Tomography 1977*, Norman D, Korobkin M, Newton TH, eds. St. Louis: CV Mosby, 1977 pp. 255-57.

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JOHN M. CORBOY, M.D.

The Communications Gap

In a recent major study of health care, three areas of consumer dissatisfaction emerged. One of those areas was the amount of *information* given to the patients by physicians. The other two were *cost* of medical care, and *waiting time* to see the physician.

It is interesting that none of these complaints deals with the technological aspects of medical care. It appears that consumers are satisfied with medicine as a science, but not with medicine as an art. Patients feel they are not receiving the information, encouragement, and reassurance that are part of the total care package, and this seems attributable to poor communications.

Patients apparently feel that physicians have stopped talking to them. Whether or not this is actually true doesn't matter: if the patient perceives that his communication needs are not being met, the therapeutic encounter simply doesn't work as it should.

The solution seems simple, even for the busiest among us. In this age of instructional films and videotapes, pamphlets, books, and ubiquitous copy machines, it seems a shame that the waiting room can't be used as a classroom. Many physicians have moved in this direction, but more effort seems needed.

Beyond this, our specialty societies and medical association could better help convey our mission to the public, through consumer forums and advisory panels. The people are woefully undereducated about costs and quality of care, and issues surrounding the provision of care.

Insufficient information not only affects consumer health care decisions, but adversely affects our profession, by making physicians easy targets for bureaucratic sharpshooters. Patients recognize that *you* have a fine reputation, but they feel that doctors as a group are less than admirable.

Perhaps it's time we all dedicate a little extra effort to helping close the communications gap. The first and easiest step is to remember those two words that should precede every patient's departure: "*Any questions?*"

Bad Medicine

In the treatment of an illness, we all agree that the attending physician stands in the best position to weigh the risks and benefits of all alternatives, and to select the treatment which best meets the needs of his unique patient.

For drug therapy, this means having a spectrum of agents from which to choose. Unfortunately, those faceless Regulators are removing bottles from your pharmacy's shelves:

Propoxyphene—because this analgesic is frequently abused, the FDA has proposed that it be removed from the market. No one questions the safety or efficacy of the drug.

Surgeon General's Advisory

The Surgeon General is concerned over the increasing use of alcohol in combination with other drugs, by both men and women. One of five drug deaths results from a drug-plus-alcohol combination.

All physicians and health professionals are reminded that:

1) The effects of many common drugs are altered by alcohol, and vice versa. These include not only sedatives, hypnotics, narcotics, antidepressants, and tranquilizers, but also certain antihistamines, analgesics, anticoagulants, and even antiinfective agents.

2) Many patients use minor tranquilizers and other depressants in combination with alcohol, despite warnings to the contrary. This combined use potentiates CNS depression and impairs alertness, resulting in increased likelihood of injury or death. The combination itself can result in death by overdose or suicide.

3) Use of marijuana and other psychoactive recreational drugs in combination with alcohol is also widespread.

Physicians and health professionals are urged to:

1) Routinely document the history and pattern of alcohol consumption to determine the possible relationship between alcohol (or drugs-plus-alcohol) and the presenting complaints.

2) Be alert to the possibility of interaction of alcohol with prescribed, over-the-counter, or illicit drugs.

3) Heed drug-alcohol interactions noted in the package insert.

4) Limit the quantity of drugs dispensed per prescription if these might be misused by the patient, and monitor for unexpected reactions.

5) When choosing therapy for a particular patient, consider the likelihood of the drug being combined with alcohol, and the likelihood of the patient's following your advice in this matter.

Amphetamines—because these are frequently diverted into illegal channels for purposes of abuse, the FDA would change the labeling so as to exclude treatment of obesity, thus making amphetamine-containing compounds virtually unavailable. No evidence suggest these drugs are not safe and effective as short-term adjuncts to obesity management.

Erythromycin estolate (Ilosone)—the FDA has requested this be withdrawn because of hepatotoxicity. Never mind that this reaction occurs once in 128,000 patients, is reversible and nonfatal, and that this ester tastes and is absorbed better than other forms of the drug.

Oral hypoglycemics—premature opinions based on controversial data would label sulfonylurea agents as “hazardous” and virtually require the use of insulin for treatment of adult-onset, nonlabile diabetes.

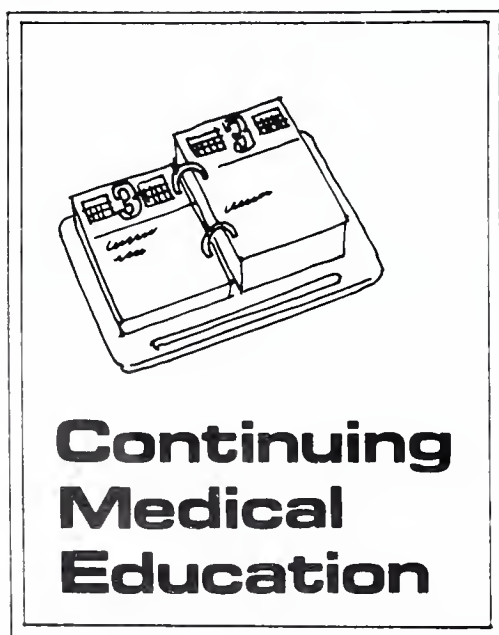
Although the FDA was mandated to assure that drugs on the market are safe and effective, this now seems perceived as a mandate to limit drugs to those which are “safest.” The ultimate bureaucratic conclusion suggests that the FDA should choose the single *safest* agent for each class; no new drug could be certified unless it were proven more effective or *safer*. Yet as we all know, there never will be a best therapy for all patients; individual responses and idiosyncracies require us to keep a variety of agents available.

The way the Regulators are making the therapeutic decisions, we won't have much therapy left!

12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all “breaks”)

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues.

10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lihala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea month. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I. (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud. First—Didactic Presentation Second—Perinatal-Neonatal Topics Third—Obstetrics Topics Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Lectures
2. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
3. G. I. Conf., Fifth Tuesday, 8:00-9:00 a.m.
4. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Endocrine & Metabolism Conf., First, Second, Third, & Fifth Wednesdays, 7:30-8:30 a.m.
6. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
7. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
8. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
9. Surgical Conf., First, Second, Third Fridays, 12:45-1:45 p.m.

10. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm. 1st—Dept. of Medicine 2nd—Dept. of Surgery 3rd—Dept. of OB/GYN 4th—Dept. of Pediatrics 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. Tumor Conf., Second Monday, 7:30-8:30 a.m. Sullivan 4—Classroom.
- *3. Tumor Mortality & Morbidity Conf., Fourth Monday, 7:30-8:30 a.m., Sullivan 4—Classroom.
4. Renal Conf., First Monday, 1:00 p.m., Sullivan 4—Classroom.
5. EENT Meeting, First Tuesday, 7:00 a.m., Medical Board Room.
- *6. Department of Medicine Mtg., Second Tuesday, 12:30 p.m., Sullivan 4—Classroom.
7. Pulmonary Conf., Second & Fourth Wednesday, 12:30 p.m., Sullivan 4—Classroom.
8. Surgery Grand Rnds. First, Second, & Third Fridays, 7:30 a.m., Sullivan 4—Classroom.
- *9. Surgery M & M Conf., Fourth Friday, 7:30 a.m. Sullivan 4—Classroom.

*For SFH Staff Members Only.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference

meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.

9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).

10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.

11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—Second Tuesday

3. Clinical Review Meeting—Alternate Mondays at noon

4. Tumor Conference—First Thursday

SPECIAL EVENTS

Apr. 12-19, 1980 Emergency Medicine, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Royal Lahaina, Maui. 30 hrs. Cat. I.

Apr. 12-19, 1980 Diagnostic and Therapeutic Skills in Internal Medicine, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Mauna Kea Beach Htl., Hawaii. 30 hrs. Cat. I.

Apr. 15 & 17, 1980

Otolaryngology, Facial Plastic & Reconstructive Surgery, Maui County Med. Soc./HMA. 1 hr. Cat. I each day, 7:00 p.m. Held on Maui. Contact: Andrew Don, M.D., Maui County Med. Soc.

Apr. 19-26, 1980

Orthopedic Review, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Mauna Kea Beach Htl., Hawaii. 30 hrs. Cat. I.

Apr. 22, 1980

PacPSRO Physicians Advisory Seminar, PacPSRO/HMA, 7:30-9:30 p.m. 2 hrs. Cat. I. Held at HMA, 320 Ward Ave., Ste. 200. Contact: PacPSRO (808) 531-8102.

Apr. 26-May 3, 1980

Management of the Surgical Patient, Stanford Univ. Schl. of Med., Stanford, CA 94305. Held at Mauna Kea Beach Htl., Hawaii. 25 hrs. Cat. I.

Apr. 26, 27, 1980

3rd Annual Seminar on Acute Care, Queen's Medical Center, 1301 Punchbowl St., Honolulu. 7:00 a.m.-5:00 p.m. April 26; 7:00 a.m.-12 noon April 27. 11 hrs. Cat. I. Contact: CME Dept., Queen's for further info.

Apr. 30-May 2, 1980

"The Patient and Transcultural Medicine," HI Regional Mtg. Assoc. of Military Surgeons of the US. Held at Tripler Army Med. Ctr. Honolulu. Contact: COL S.A. Cucinell, Clinical Investigation Serv., Tripler AMC, HI 96859 (808) 433-6709.

May 3-11, 1980

California Soc. of Anesthesiologists, San Mateo, CA. Held at Intercontinental Htl., Maui, and Hyatt Regency, Waikiki.

May 4, 1980

Symposium on Human Nutrition, Lederle Labs/HMA. 6 hrs. Cat. I, & AAFP. Held at Ilikai Htl., Honolulu. Contact: CME Dept. HMA, 320 Ward Ave. Ste. 200, Honolulu, 96814 (808) 536-7702.

May 10-17, 1980

Pediatric Workshop, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Royal Lahaina, Maui. 30 hrs. Cat. I.

May 11-17, 1980

Modern Trends in Emergency Medicine, co-sponsored by National Emergency Services Inc.; HI Chapter of Emergency Physicians & John A. Burns Schl. of Med. CME Dept. (808) 947-8573 or (808) 948-7457.

May 23-31, 1980

Diving Medicine, 1980 Update. John A. Burns Schl. of Med., Honolulu. Held at Kauai Surf Htl. 35 hrs. Cat. I.

July 26-Aug. 2, 1980

Cardiovascular Med & Surg., An Advanced Course. Stanford U Schl of Med., Stanford, CA 94305. 22 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI.

July 28-Aug. 1, 1980

Med. Knowledge Self-Assessment Pgrm V. Am. Coll of Phys., 4200 Pine St., Philadelphia, PA 19104. Co-sponsor-J.A. Burns Schl of Med. U of H. 30 hrs. Cat. I. Held at Kuilima Hyatt Resort Htl., Honolulu. Contact: Dr. Irwin J. Schatz, (808) 546-2810.

Aug. 9-Aug. 16, 1980

Ophthalmology—U of S. CA Schl of Med., 2025 Zonal Ave., L.A., CA 90033. 28 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI.

Aug. 16-Aug. 22, 1980

Stress & The Physician—Honolulu Med. Grp. Research Ed. Found., 505 So. Beretania St., Honolulu 96813 (808) 537-2211, ext. 751. 22 hrs. Cat. I. Held at Hyatt Regency Maui Htl., Maui, HI.

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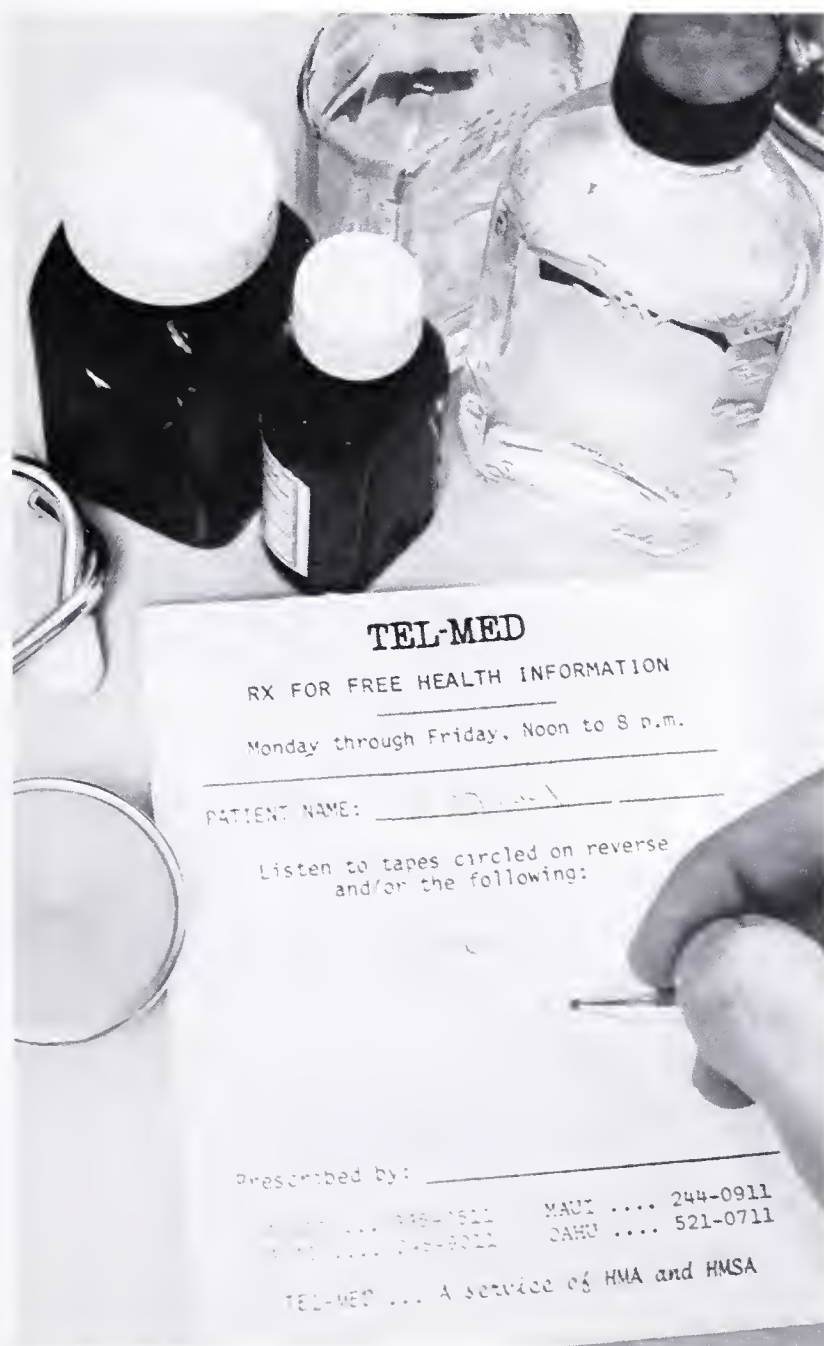
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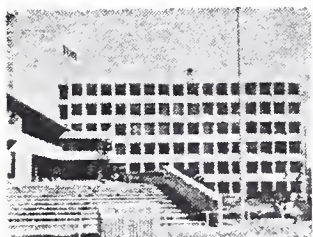
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PRESIDENT

January 11, 1980

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Members of Hawaii Medical Association
Hawaii Medical Association
320 Ward Avenue, Suite 200
Honolulu, Hawaii 96814
U.S.A.

Dear Members:

We are very much indebted to you for your gorgeous and superb hospitality extended to our group in spite of your busy schedule. Our team has safely returned Hiroshima on the 6th of January with such a wonderful experience in Hawaii.

It was indeed our great pleasure to meet many friends every day of our stay to whom we were able to renew and deepen our friendship and were able to discuss our mutual interests.

Your members had to take us to various places by their own cars being non-paid chauffeurs with perfect arrangement, and we are very much grateful. It is our hope that both of our associations will keep continuing our friendship and contributing to promote the health and welfare for the nations of both countries. Your kind cooperation would be greatly appreciated.

With our best Aloha and regards to all of you, we remain.

Sincerely yours,

Masami Aoyama, M.D.
Vice President

Masami Aoyama

Taiji Okada, M.D.

Taiji Okada

Y. Noma
Yusuke Noma, M.D.

Hiroomi Matsubara, M.D.

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Shige-yuki Fjii

Sumio Sugimoto, M.D.

S. Sugimoto

Goro Ohuchi

Goro Ohuchi, M.D.
President



**January 11, 1980, 5:30 p.m.
HMA CONFERENCE ROOM**

PRESENT

Drs. Bell, Winn, Lum, Hindle, Goto, Chinn, Kam, Don, Lumeng, Morgan, Shirasu, Bruce, Cahill, McNamee, Wigle, Fu, Char, Dang, Simmons, Uemura, Lee, and Mrs. N. Simmons. HMA Staff present were: Messrs. Won, Saranchock, Leineweber, Ajifu; and Mmes. Kendro, Chang, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 6:05 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of December 31, 1979 which indicated that HMA membership totaled 925 in comparison with December 1978 when membership totaled 903.

REPORT OF THE TREASURER:

The November 1979 financial statement was reviewed in detail and approved subject to audit. The Council noted that the HAWAII MEDICAL JOURNAL is operating at a deficit. A recommendation was made that the Publications Committee be requested to evaluate this matter.

ACTION:

It was moved, seconded, and passed that the Publications Committee be instructed to report to the Finance Committee on how to balance the Journal's budget for the coming year either by increasing its revenues or by decreasing its costs.

Dr. William Hindle, Treasurer, requested that the Council consider changing the HMA's present check-signing policy which requires two authorized signatures for payment. Dr. Hindle pointed out that checks under \$100 are generally of a routine nature; and he recommended that for checks of \$100 or less, Council require only *one* authorized signature for authorization of payment.

ACTION:

It was moved, seconded, and passed that for Association checks of \$100 or less, only one authorized signature will be required for authorization of payment; and that checks amounting to over \$100 would require two authorized signatures.

REPORT OF THE AMA DELEGATE:

Presented to the Council was the AMA Delegate's Report, prepared by AMA staff, which highlighted the deliberations of the House at the recent AMA Interim Meeting in Honolulu. Dr. Chinn encouraged members of the Council to review the report. It was agreed that the report be sent to the county societies for their information.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. HMA Annual Meeting: Convention Chairman, Dr. Herbert Uemura, reported that for 1980, HMA will sponsor its own scientific sessions since the AMA does not plan to bring its regional meeting to Hawaii this year. The Annual Meeting is scheduled for the week of October 13-17, 1980. Convention sites under consideration are the Ilikai Hotel and Pacific Beach Hotel. While tentative reservations have been made with both facilities, a final commitment has not been made as the HMA is awaiting estimates from the hotels. In view of time constraints involved in preparing for the annual meeting and scientific program, a recommendation was made that the Council authorize the Convention Chairman to choose the location.

ACTION:

It was moved, seconded, and passed to authorize the Convention Chairman to choose the location for the 1980 Annual Meeting.

B. Update on PacPSRO: Dr. Winfred Lee provided the Council with an update on Pacific PSRO. Outlined were PacPSRO's goals as well as current national objectives. Dr. Lee discussed in depth the major problem areas faced by PacPSRO which are as follows: (1) Level of funding—severe fiscal constraints regarding funds to carry out its review activities, (2) Current threat of defunding, and (3) Confidentiality. With respect to confidentiality, Dr. Lee noted that Judge Gesell's ruling, with regard to the availability of PSRO information, is presently being appealed. In discussing the future of PSRO, Dr. Lee emphasized that if PacPSRO is defunded, it would not necessarily mean that review by Federal bodies is gone. What was stressed by members of the Council and Dr. Lee was the desire of physicians to provide optimum medical care for patients.

C. Public Affairs: Dr. Philip McNamee reported that the Public Affairs Committee was given a grant of \$100 for the establishment of a new award. The Committee recommended that HMA begin an annual award to a physician for excellence in medical journalism (journalistic reporting in either print or electronic media).

ACTION:

It was moved, seconded, and passed that HMA begin an annual award to a physician for excellence in medical journalism. There was one opposing vote.

While the concept of the new award was approved, the Council stressed that it could not approve funds

that involve budgets for forthcoming years. The Council recommended that the Public Affairs Committee try to seek a benefactor for such an award.

D. Legislation: Dr. George Goto reported that the Tenth State Legislative Session will open on January 16, and HMA will send a plant to each legislator to commemorate the opening festivities. The Council was informed that Mr. Kazuhisa Abe has agreed to serve as HMA's legislative counsel on an as-needed basis. Issues expected to arise this year are generic drugs, Medicaid, chiropractic, patients' rights, and the establishment of a statewide medical examiners system. In discussing chiropractic bills, the Council felt that HMA should not get involved in the controversy within the chiropractic groups.

E. Medicaid: Dr. E. Lee Simmons reported that a meeting was held with DSSH representatives for the purpose of having an informal exchange of viewpoints regarding the Medicaid issue. The Medicaid Committee plans to send a letter to each legislator to express HMA's concern with regard to provider reimbursement under the Medicaid Program. Dr. Simmons also briefed the Council on the AMA-sponsored state health legislation workshop which he recently attended in Phoenix on behalf of HMA.

F. Hiroshima Visitation: Dr. Bell reported that HMA was visited by the Board of Directors of the Hiroshima Prefectural Medical Association from January 1-5. HMA representatives enjoyed several meals with the Hiroshima doctors as well as a joint scientific session.

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G. CME: Dr. Nadine Bruce presented the CME Committee's recommendation with regard to a proposal for HMA to charge a fee for co-sponsorship when unaccredited organizations request Category I accreditation through the HMA's Medical Education Committee.

ACTION:

It was moved, seconded, and passed that in all tuition courses, a fee will be charged to co-sponsor Category I programs. The fee shall be \$25 baseline for all programs up to and including 10 hours of Category I, a baseline fee of \$50 for all programs over 10 hours of Category I, and with the option for the Medical Education Committee to charge up to \$150 for either of these two groups for special circumstances (such as problems in processing the applications, amount of counseling necessary to set up the program, etc.)

H. EMS: Dr. William Dang reported that the DOH has verbally informed HMA that the EMS Program will be funded until June. Although a contract has not been finalized, it was noted that the DOH has been providing funds to the EMS Program on a fee-for-service basis. The Program is preparing a grant for a training program on the neighbor islands.

I. Medical Services: Dr. Dang reported that the Fee Survey Committee is working on revision of the Current Procedural Terminology manual.

J. Health Service and Care: Dr. Donald Char reported that the Health Manpower Committee recently held meetings with nurse practitioners and physicians assistants. In discussing the SHCC Manpower Task Force report on physician manpower, the Council felt that the statistics could have important implications for the UH School of Medicine. The Council reaffirmed its present stand that HMA supports the Medical School as long as it is economically feasible.

Dr. Char reported that other task force reports have emerged on the subjects of long term care, acute bed care, behavioral health, perinatal care, end-stage renal disease, and HMOs; and it is anticipated that the Community Health Care Committee will review these reports. The Council was also brought up to date on Dr. Char's involvement on the Functional Health Committee, which is reviewing the health section of the State General Plan.

K. Public Health: Dr. Thomas Cahill reported that the Chronic Illness Committee is conducting a survey of the membership to identify physician members who will accept geriatric patients.

L. Computer: Mr. Jon Won reported that the central processing unit has been delivered to the BME. Under the coordination of Becky Kendro and Andrew Saranchock and with the help of part-time temporary personnel, present manual records are being converted to the computer format, with emphasis on membership and CME. Between now and February 1, HMA will be involved in staff training and testing of the system.

M. Jail Health Care Project: Mr. Jon Won announced that a committee has been formed to spearhead the Jail Health Care Project. The members are Drs. Walter W. Y. Chang, Chairman, Nadine Bruce, James Lumeng, Albert Chun-Hoon, and Neal Winn. On December 27, an orientation session was

held for all jail administrators, and it is expected that self-surveys will be returned by the end of January. An orientation session will also be held for this newly formed committee, and the physicians will be looking at enlarging the committee to include representatives from the community. Mr. Won noted the likelihood that HMA would be included in the program until April 1982, and commented that HMA would receive funds of up to \$39,000 a year.

N. Gerontology Center: Members of the Council reviewed HMA's letter written to the Chairman of the Gerontology Center of Hawaii, as directed by the Council at its last meeting. A recommendation was made that the HMA study the feasibility of developing a Gerontology Center, with report monthly on the progress of the study of the Council.

ACTION:

It was moved, seconded, and passed that HMA study the feasibility of developing a Gerontology Center, with report monthly on the progress of the study to the Council.

O. Membership Recruitment: On behalf of the HCMS Membership Recruitment Committee, Dr. Myron Shirasu issued a challenge to the members of the Council to recruit at least one new member by the end of the year into the HCMS, HMA, and AMA under the Membership Incentive Program.

In discussing membership incentives and access to leadership positions, the Council agreed that an ad hoc committee be appointed to study current methods of electing members into leadership positions and the structure of the HMA Council (with regard to the possibilities of specialty society representation, at large representation, chairman of the Council, etc.).

REPORTS OF COUNTY SOCIETY PRESIDENTS

A. Honolulu: Dr. Thomas Cahill reported that the Society will hold its first membership meeting of the year on February 12 which will focus on current topics such as the HMA's plans to publish a procedural terminology manual, Medicaid, and legislation. The Society is presently conducting a review of its bylaws.

B. Maui: Dr. Andrew Don reported that the Society held its annual Christmas dinner on December 15. Four of the Society's retired members who have been active for 25 years were honored at this meeting. The Society has established an ad hoc committee to look into incorporation of the Society. Maui County has planned a joint meeting with pharmacists to discuss generic drug substitution.

C. Hawaii: Dr. Arch Wigle reported that the Society will hold a membership meeting with the HMSA representatives from Hawaii as the featured guest.

OTHER BUSINESS

Auxiliary: Mrs. Nancy Simmons reported that she recently had the pleasure of installing the new Maui Auxiliary officers. She also reported that the HMA Auxiliary will hold a legislative workshop on January 23. Council members were reminded of the Auxiliary's fund-raiser for the Hawaii Medical Library on April 19.

ADJOURNMENT:

The meeting adjourned at 9:50 p.m.



Hawaii Academy of Family Physicians' Newsletter

DON and MARLIES FARRELL

Members of HAFP are saddened by the loss of **Jean Reppun** who died on February 12. Jean served as Executive Secretary from 1972 to 1979. There is hardly a member who does not remember instances of Jean's kindness and helpfulness, be it with phoned reminders of dinner meetings, untangling of membership mix ups or sorting out CME credits. Our sympathy to Fred and his family, we will miss Jean.

This month we list three new members: **Baron K. F. Ching** joins us as a student member; new active members are **Reginald S. Carvalho** of Hilo and **Harold K. Merselis** of Pukalani, Maui who transferred in from the Iowa chapter.

The following members were reelected to three year active memberships: **Patrick M. Cockett, Donald L. Farrell, Mary A. Glover, Milton Howell, Lincoln Luke, John Newman** and **Patrick Walsh**.

Dr. Ernest Santos was reelected an inactive member.

At the February 21 Executive Council meeting President **Patricia Dietrich** appointed the following committee-chairmen:

Constitution & Bylaws: **Fred Reppun**

Healthcare Services: **James Tsuji**

Education: **Michael Hase**

Legislative Contact: **Thomas Cahill**

Membership: **Glenn Stahl**

The next Executive Council meeting will be held on March 20 at HMG. This is an urgent reminder to those members who are due for reelection and have not yet submitted their credit hours, to do so before that date.

Watch your mail for details on our next dinner meeting to be held on April 26 at the home of **Dr. and Mrs. Garton Wall**. Mark your calendars now. The program will include a presentation by noted rheumatologist Dr. Singleton and a movie about the annual AAFP meeting in New Orleans, sponsored by the Stewart Pharmaceutical Co.

Nathan A. K. Wong, a family physician with Kaiser has been chosen as a crew member for the Hokule'a, the Hawaiian Voyaging Society Canoe. He will take part in the return trip from Tahiti, tentatively

scheduled for early May. Depending on weather conditions, the return voyage should take between three and five weeks to complete. The major purpose of the voyage is to develop a noninstrumental navigational system similar to the one believed to have been used by ancient Polynesian voyagers. Bon Voyage, Nate!



Roman W. Glamb, M.D.
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crisp, refreshing, easy to read format, basic knowledge and current developments of general surgery and the surgical specialties are presented. It leaves no facet of surgical care neglected, but deals with each subject in sufficient depth. Many chapters have been newly rewritten and the entire book has been revised and updated. The index is cross referenced; the bibliographies are current; and, the soft cover makes it a comfortable workbook. It should be recommended to any student of surgery or practitioner.

KENT TOWSLEY M.D.
Surgical Resident
University of Hawaii

Hawaii's Poisonous Plants

Roger E. Baldwin, Ph.D., 112 pp., \$5.50, The Petroglyph Press, 1979.

This informative, attractive paperback effectively assembles a plethora of beliefs, pharmacologic data, and taxonomic information about poisonous plants found in Hawaii. In the author's words, it will "help you, the reader, to know which plants to avoid and what to do when poisonings occur." In the selection of plants for his book Dr. Baldwin has included those plants in Hawaii which have been involved with poisonings, those with significant toxicity, and those with high probability of human exposure to them.

The book is written to be useful to those with no special botanic or medical knowledge. It does contain many technical terms, well defined in a glossary.

For the physician or chemist the brief toxicological information given can be very useful. For the botanist an appendix addresses the problem of alternate taxonomy. The basic system used is that of Cronquist (The Evolution and Classification of Flowering Plants, 1968).

The plant drawings by William Walker are excellent, permitting the reader a good chance of correct field identification of illustrated specimens.

Dr. Baldwin acknowledges the work of Dr. Rea Chittenden of the Poison Information Center in Honolulu who contributed to the medical accuracy of this book.

This little volume should be in the library of everyone interested in the fascinating toxicology of some of Hawaii's most common plants.

FRANK L. TABRAH, M.D.

Our "Angels"

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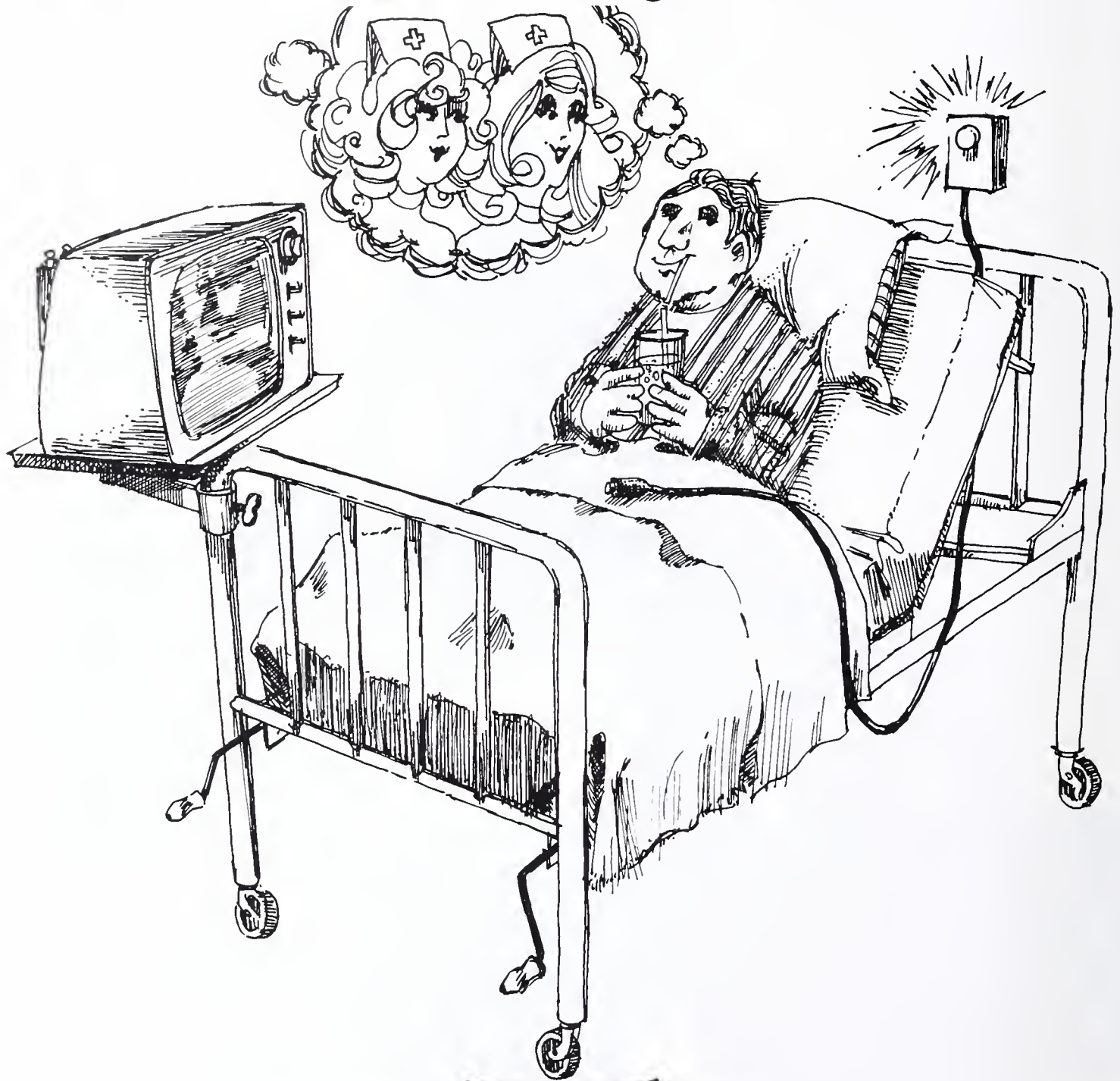


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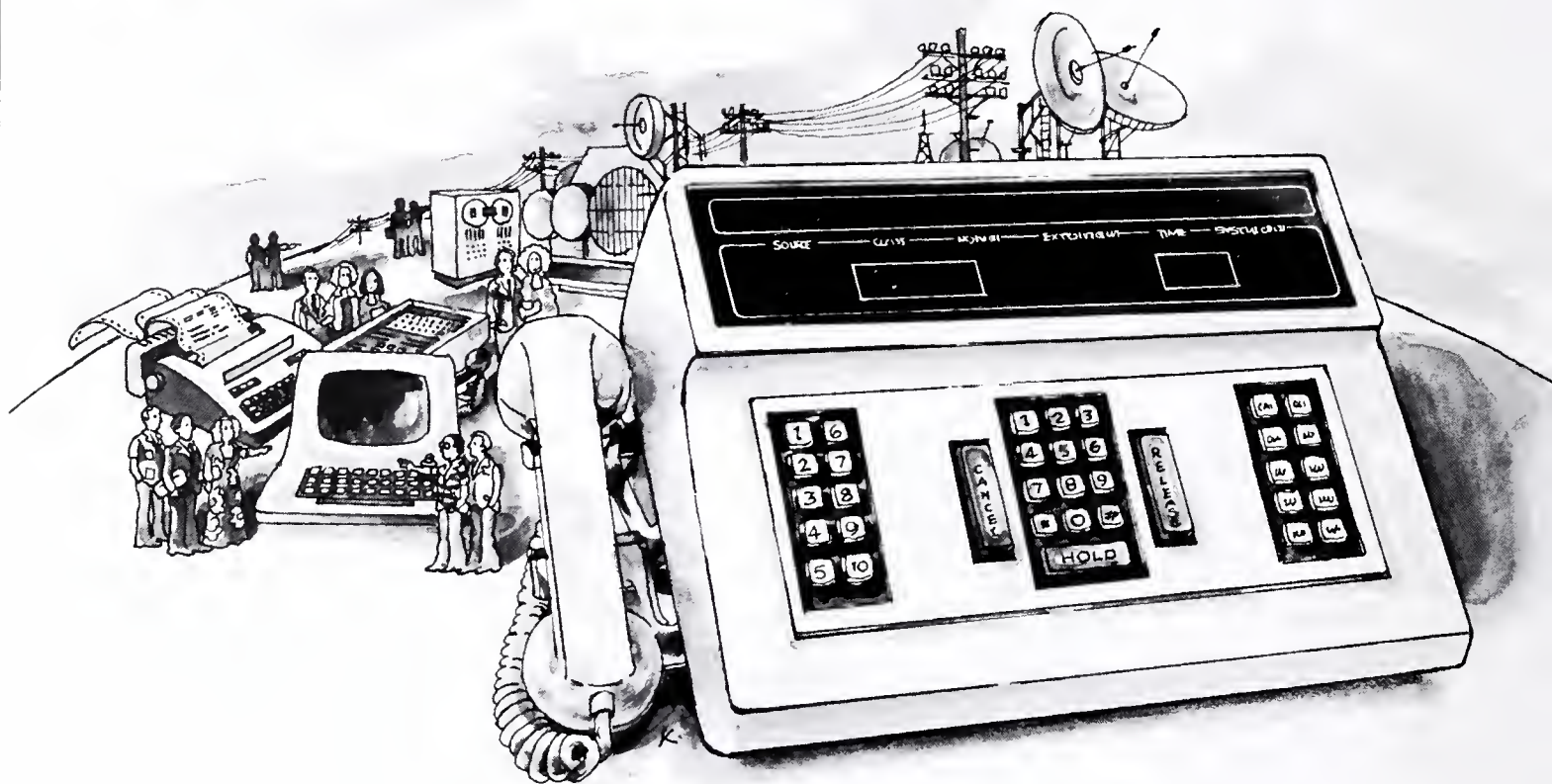
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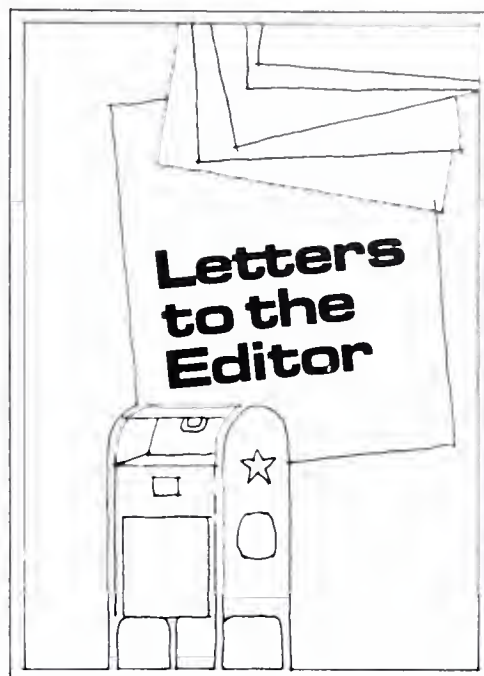
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To the Editor:

Reference is made to the January 1980 issue of the HAWAII MEDICAL JOURNAL. I wish to express my extreme disappointment in the supercilious and cavalier reporting of HMSA's participation at the Honolulu County Medical Society's meeting on November 5, 1979 which appears on Page 24 under the subject "NEWS and NOTES." I sincerely hope this is not an example of the respect and treatment that the Medical Profession accords its guests.

HMSA Officials were invited as guests of the Honolulu County Medical Society to review our operations within the context of today's important environment of public concerns of high cost of Medical Care, Cost Containment activities and National Health Insurance—all very serious subjects. We prepared a concise presentation of educational and communications value and following the meeting received many phone calls from physicians in attendance complimenting our participation and expressing appreciation for the update on HMSA activities.

It is beyond my comprehension why the writer, who admittedly was an hour late in arrival, thereby missing the entire presentation and who admittedly states "... we are writing all this from fragmentary notes" would use this forum to cause division at a time when cooperation is imperative to all of us. Furthermore, why didn't he quote the physician who declared from the floor at the end of the meeting "I think HMSA is doing an excellent job. Let's give them a big hand" and the unanimous and enthusiastic round of applause we received?

I am frankly more disappointed in the HAWAII MEDICAL JOURNAL's editorial staff and the Hawaii Medical Association for allowing such dribble to be printed. It may appear to be facetious and a lark, but let me assure you that the subjects under discussion and our presentation were very serious and we believe that we handled the questions from the floor factually and accurately.

It is interesting to observe that most of the exchanges from the floor reported by the writer dealt with "money" and not the vital concerns of what's ahead of us in the health delivery system.

(Continued on page 98)

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Massive Thrombosis in SLE

MICHAEL J. O'LEARY, M.D., PANU LIMPISVASTI, M.D., ROBERT A. NORDYKE, M.D.,
and ROBERT L. KISTNER, M.D., *Honolulu*

● *Thrombophlebitis can be an intermittent and potentially serious complication of Systemic lupus erythematosus (SLE). It is found in about 12% of patients. The frequency of this problem, its tendency to recur, and its incidence in patients without other evident predisposition to thrombosis indicates an underlying hemostatic abnormality. The patient presented has had multiple episodes of deep venous thrombosis subsequent to his diagnosis of SLE in spite of his young age, normal level of physical activity, and absence of other apparent predisposing factors.*

CASE REPORT

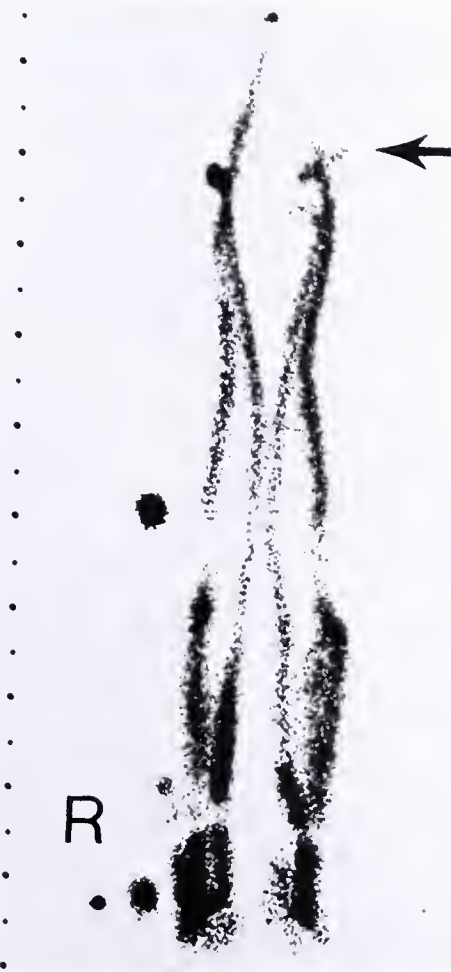
A 13-year-old boy was first admitted to the hospital in May, 1977, because of cough, pleuritic chest pain and a right-sided friction rub. The Hgb was 8.3 gm/dl and the urinalysis revealed many wbc's and rbc's with proteinuria. Serum complement was 55 ng/dl (normal 80-165). He was treated with antibiotics for probable streptococcal pneumonitis. In February, 1978, the patient was readmitted to the hospital because of fever, cough, chest pain, hemoptysis, and a gradual enlargement of his left leg. Studies revealed thrombosis of the left iliac vein (Fig. 1) and pulmonary embolism.

Thrombectomy was performed, at which time numerous enlarged lymph nodes were found, some of which were adjacent to the site of thrombus. Biopsy of a lymph node was reported as a reactive hyperplasia.

Further studies revealed a positive ANA, LE cells, 29% DNA bound (normal up to 20%). His ESR was 57 mm/hr (Wintrobe method). C3 complement was 88 ng/dl. Complete blood count showed leukopenia, thrombocytopenia (80,000/mm³), and a Hgb of 9.0 gm/dl. He also developed pericarditis.

A swollen left forearm was explored with biopsy, showing necrotizing myositis and vasculitis. Urinalysis still demonstrated micro-

FIG. 1—Nuclear scan of the iliac vein



hematuria. The diagnosis of systemic lupus erythematosus was made and he was treated with steroids and anticoagulants with remarkable improvement.

In March, 1978, the patient was readmitted because of painful swelling in the right shoulder and was found to have complete occlusion of the right axillary vein with abundant collaterals by radionuclide venography (Fig. 2). He was again anti-coagulated. C3 complement returned to normal as did DNA binding, although ANA remained positive. His Hgb had risen to 11.9 and platelets to 132,000/mm³. Microhematuria and low grade proteinuria persisted. He was discharged on coumadin, but 3 days later developed pleuritic chest pain and dyspnea and was read-

Requests for Reprints should be addressed to: P. Limpisvasti, M.D., Department of Medicine, Straub Clinic & Hospital, Inc., 888 South King Street, Honolulu, Hawaii 96813.

Accepted for publication August, 1979.

FIG. 2—Nuclear scan of the right axillary vein

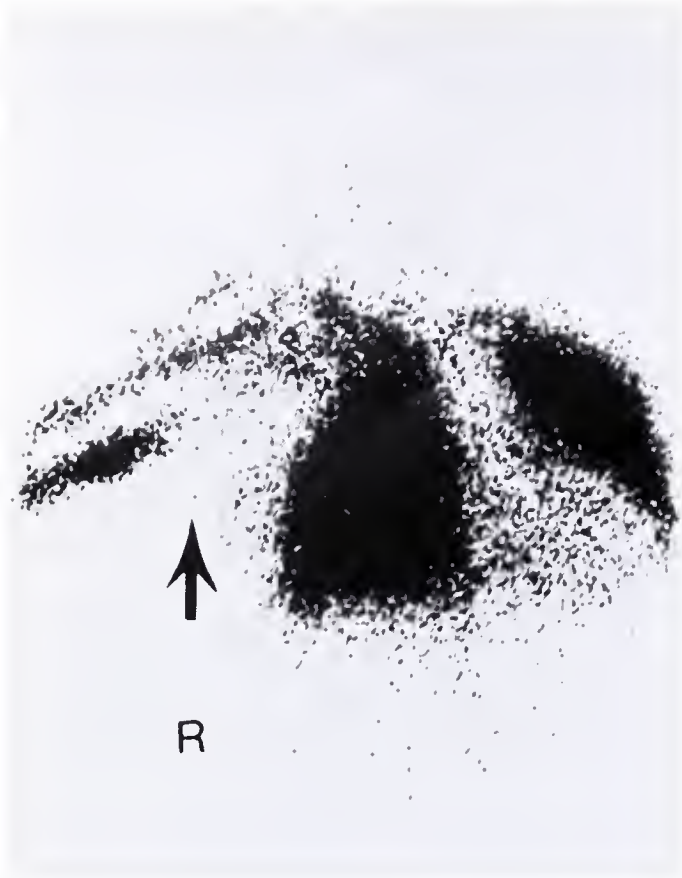


FIG. 3—Infrared photograph of right shoulder



FIG. 4—Infrared photograph of legs



mitted. An echocardiogram showed pericardial effusion. There was no evidence of new pulmonary embolism, anti-thrombin III was normal at 100%, EEG showed mild bilateral slowing and a radio-nuclide brain scan was normal. The patient responded well to an increase of prednisone to 80 mg/day and continuation of coumadin.

Two months later he developed a herpetic eruption in the distribution of C3 on the right and the following day had 4 grand mal seizures. He was noted at hospitalization to have a right homonymous hemianopsia with decreased visual field on the left. EEG showed slowing and irregularity, right side more than left, and radionuclide brain scan and computerized tomography of the head were normal. Creatinine clearance had fallen from 124 to 64 m./minute with 24 hour urinary protein excretion rising to 2.04 gm. Prednisone was increased from 55 to 80 mg/day. Dilantin and phenobarbital were added to his regimen. After discharge the patient began receiving Azathioprine (Imuran) and his prednisone was decreased. Four months later the coumadin was discontinued.

On December 1, 1978, after a period of excessive physical activity and sun exposure, the patient was hospitalized because of fever, chills, and thrombophlebitis of a superficial vein in his left leg (Fig. 3 and 4). There was no evidence of new thrombosis of the deep venous system by Doppler ultrasound or phlebogram. Repeat radionuclide venograms showed persistent ab-

normal collateralization of his left iliac and right axillary veins. Because of his apparent hypercoagulability with a prothrombin time of 11 seconds (control 12) and PTT 27 seconds (control 40), radionuclide kidney blood flow and imaging were performed to evaluate for possible renal vein thrombosis; none was found. His 24-hour urine protein, however, was 2.02 gm. The C3 complement was 151 mg/dl, ESR 12 mm/hr and creatinine clearance 106 ml/min. His platelet adhesiveness test was 89% (normal 26-60%) and remained elevated at 86% after a trial of enteric-coated aspirin 650 mg twice daily. The patient again responded well to an increase in prednisone from 45 to 60 mg/day.

Discussion

Abnormal hemostasis has been increasingly recognized in SLE, and a number of reports have dealt with thrombophlebitis.¹⁻⁶ Armas-Cruz⁷ in 1958 found 13 cases of thrombophlebitis in 108 patients with lupus, and Peck *et al*² in 1978 noted thrombophlebitis in 14 of 114 patients. As means

of detecting deep venous thrombosis have become more sophisticated, it is clear that thrombophlebitis is not an infrequent occurrence in SLE.

Disruptions in hemostasis can present as a tendency to bleeding as well as to thrombosis. Circulating anticoagulants have been demonstrated for a number of years in SLE, and recent evidence suggests that these may be immunoglobulins of the IgG and IgG + IgM class directed against factors IX and XI.^{8,9} A qualitative platelet defect frequently exists, as well as a probable antiplatelet factor. Even in patients with the above deficiencies in hemostatic factors, venous and arterial thrombosis seems paradoxically more common than hemorrhage.

Several mechanisms of thrombotic episodes have been postulated: autoimmune venulitis and arteritis, triggering platelet aggregation and thrombus formation; coagulation system activation as a response to immune complex deposition;⁶ compensatory hypercoagulation state in response to circulating anticoagulants, with increased levels of thromboplastin;^{2,4} a similar platelet compensatory state in patients with antiplatelet antibodies—the “compensated thrombocytolytic state”;¹⁰ and possible contributions in some situations from chronic disseminated intravascular coagulation,^{2,5} macroglobulinemia,⁵ and, although these do not seem to be operative in most reported cases. Except for increased thromboplastin generation, there is little firm evidence to support these postulations and they remain speculative.

It is also not clear whether the tendency to thrombosis is related to the activity of disease. In the case discussed, the patient had active diseases at the time of his initial iliac thrombosis, but the lupus was relatively quiescent when he presented with right axillary thrombosis. However, it should be noted that 3 days after discharge the patient was readmitted with pericarditis.

Other investigators have commented on the occurrence of episodes of thrombophlebitis preceding flares of disease, and at times preceding diagnosis.^{3,11} Peck *et al*² reported their series of thrombophlebitis on patients with “active” SLE, and others have described normalizations of clotting studies as disease become quiescent. Sergeant *et al*⁶ found a significantly shortened T_{1/2} for fibrinogen associated with elevated anti-DNA binding, with normalization of the half-life after

remission was induced (in 2 patients studied). Regan *et al*⁹ studied qualitative platelet defects in patients with SLE, and found that those who did not show platelet aggregation responses (to induction with collagen, ADP or epinephrine) tended to have more active disease and were younger than responders; one patient reversed her platelet aggregation defect when the disease was treated successfully with prednisone.

Renal vein thrombosis and pulmonary embolism are two entities which deserve special consideration. The former has been reported a number of times in patients with lupus;^{11,12} increases in clotting factors have been demonstrated (factors V, VII, VIII, X, increased platelets, fibrinogen, and accelerated thromboplastin generation).

However, this same tendency to thrombosis of the renal vein is found in patients with nephrotic syndrome without SLE. It has been postulated that the hypercoagulability is on the basis of nephrosis alone, possibly because of a nonspecific hepatic response to proteinuria, producing an increase in clotting factor production.

The case discussed in this paper had neither nephrotic syndrome nor renal vein thrombosis, but clearly had a tendency to hypercoagulability.

Pulmonary embolism is important for another reason. Pleuritis is a known presentation of lupus, and pulmonary embolism can produce an identical pleuritic pain which requires entirely different management. Undoubtedly, a number of cases of chest pain have in the past been mistakenly attributed to the pleuritis of SLE, when thrombi from deep venous thrombosis were responsible.

The presentations of SLE are diverse, and thrombophlebitis has probably received insufficient recognition. It is particularly important because the nephrotic syndrome frequently accompanies lupus, and associated renal vein thrombosis is a potentially serious complication. When presented with a patient with pleuritic chest pain, it is important to consider deep venous thrombosis with pulmonary embolism in the differential diagnosis, as well as the long-recognized pleuritis of SLE. No doubt, increased awareness of the occurrence of thrombophlebitis in lupus will result in more cases being recognized and reported.

REFERENCES

1. Lowman EW, Slocumb CH: The peripheral vascular lesions of lupus erythematosus. *Ann Intern Med* 36:1206, 1952
2. Peck B, Hoffman GS, Franck WA: Thrombophlebitis in systemic lupus erythematosus. *JAMA* 240:1728, 1978
3. Alarcon-Segovia D, Osmondson PJ: Peripheral vascular syndromes associated with systemic lupus erythematosus. *Ann Intern Med* 62:907, 1965
4. Bowie EJW, Thompson JH Jr, Pascuzzi CA *et al*: Thrombosis in systemic lupus erythematosus despite circulating anticoagulants. *J Lab Clin Med* 62:416, 1963
5. Bridi GS, Frayha RA: Lupus glomerulitis and renal vein thrombosis. *Br Med J* 1:750, 1976
6. Sergeant JS, Sherman RL, Al-Mondhiny H: Fibrinogen catabolism in systemic lupus erythematosus. *Arthritis Rheum* 19:195, 1976
7. Arams-Cruz R, Harnecker J, Ducach G *et al*: Clinical diagnosis of systemic lupus erythematosus. *Am J Med* 25:409, 1958
8. Castro O, Farber LR, Clyne LP: Circulating anticoagulants against factors IX and XI in systemic lupus erythematosus. *Ann Intern Med* 77:543, 1972
9. Regan MG, Lackner H, Karparkin S: Platelet function and coagulation profile in lupus erythematosus. Studies in 50 patients. *Ann Intern Med* 81:462, 1974
10. Karparkin S, Garg SK, Siskind GW: Autoimmune throm-

- bocytopenic purpura and the compensated thrombocytolytic state. *Am J Med* 61:1, 1971
11. Appel GB, Williams GS, Meltzer JI et al: Renal vein thrombosis, nephrotic syndrome, and systemic lupus erythematosus. An association in four cases. *Ann Intern Med* 85:310, 1966
 12. Kendall AG, Lohmann RC, Dossetor JB: Nephrotic syndrome—a hypercoagulable state. *Arch Intern Med* 127:1021, 1971
 13. Karparkin S, Lackner HL: Association of antiplatelet antibody with functional platelet disorders. Autoimmune thrombocytopenic purpura, systemic lupus erythematosus and thrombopathia. *Am J Med* 59:599, 1975
 14. Karparkin S, Strick N, Karparkin MB et al: Cumulative experience in the detection of antiplatelet antibody in 234 patients with idiopathic thrombocytopenic purpura, systemic lupus erythematosus and other clinical disorders. *Am J Med* 52:776, 1972
 15. Hamilton CR Jr, Tumulty PA: Thrombosis of renal veins and inferior vena cava complicating lupus nephritis. *JAMA* 206:2315, 1968
 16. Dubois EL, Arterberry JD: Gangrene as a manifestation of systemic lupus erythematosus. *JAMA* 181:366, 1962
 17. Thomson C, Forbes CD, Prentice CRM et al: Changes in blood coagulation and fibrinolysis in the nephrotic syndrome. *Q J Med* 43:399, 1974
 18. Khan MA, Ricanati ES, Chung Park MJ: Lupus nephritis and renal vein thrombosis (letter). *Ann Intern Med* 86:114, 1977

Who wants to be the first to test this modest proposal?

Without Reasonable Compensation, Must the Physician in Hawaii Consent to Serve as an Expert Witness?

GARY J. BYRD, M.D.

Physicians of every specialty are being called to serve as medical expert witnesses in courts of law in increasing numbers, as the number of medically related cases being heard constantly increases. It has been estimated¹ that up to 85% of all cases tried have medical implication. Occasionally the physician called is a specialist in forensic medicine, and is familiar with and prepared for the task. In most cases, the physicians called to testify are primarily clinicians who may not be aware of their rights and duties as an expert witness.

The differences between the role of a fact witness and the role of the expert witness will be presented; the status of medical expertise as property will be examined; the basic constitutional rights of the medical expert will be stated; the current status of the related law in Hawaii will be reviewed; and the alternatives available to the physician in Hawaii called to be an expert witness

will be considered.

Generally witnesses in courts of law may be divided into two main groups: fact witnesses and expert witnesses. A fact witness may be anyone, regardless of his station in life, who may possess relevant factual information about an issue in litigation. In the courtroom, the fact witnesses simply respond to direct questions from the trial attorneys without the ability to include within their answer opinions or speculation.

In contrast, a witness must be particularly qualified to be an expert witness. Qualifications usually are based upon the possession of specialized knowledge gained by training, experience or both. Testifying in the capacity of an expert witness, an individual may do one or more of the following: (a) render professional opinions based on facts; (b) come to conclusions; (c) entertain hypothetical questions; (d) detail technical procedures to the judge or jury; (e) insist upon rephrasing of ambiguous questions by the attorney; and (f) modify or amplify an answer when a yes or no answer could be misleading.

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Accepted for publication, January, 1980.

The testimony of a medical expert witness is based upon years of formal education, special training, and clinical experience. It is apparent that such medical expertise has all of the characteristics of property. Property has been defined judicially² as, "Every interest anyone may have in any and everything that is the subject of ownership by man, together with the right to freely possess, use, enjoy, or dispose of same."

The Pennsylvania Supreme Court placed medical expertise squarely within this category when it included within a formal decision³ the following: "The private litigant has no more right to compel a citizen to give up the product of his brain than he has to compel the giving up of material things."

Therefore, since expert medical testimony is equivalent to property, it would follow that without reasonable compensation, such property cannot be demanded of a physician without violating the due process provisions of the 14th Amendment to the United States Constitution. Even with an offer of compensation, the physician could raise the 13th Amendment to the United States Constitution which prohibits involuntary servitude and refuse to be an expert witness on that basis.

In Hawaii every person properly summoned is required to attend and give testimony unless specially exempted or privileged.⁴ The witness fees in criminal cases are \$4.00 (four dollars) per day plus 20¢ (twenty cents) per mile when the witness resides on the same island as the court. If the witness resides on a different island, the fees are \$6.00 (six dollars) per day and 20¢ (twenty cents) per mile.⁵ The same fees are paid witnesses in civil cases.⁶

There is no allowance for reasonable compensation for expert witnesses. However, it would seem that expert witness fees may, at times, be paid, but not as a matter of law, as indicated by a ruling of the Hawaii Supreme Court⁷ which contained the statement that expert witness fees could not be taxed to the losing party in a civil suit.

Although it may be standard practice to com-

pensate the medical expert in Hawaii, since there is no statutory requirement for such compensation nor is there a judicial decision in a court of record in Hawaii which would mandate paying such compensation, it is important to consider the alternatives available to the physician in Hawaii who may be called to be an expert witness without any offer of reasonable compensation. In such a situation, the physician could appear in court and discharge any duties that he might have as a fact witness. Subsequently, he could respectfully refuse to testify as an expert witness based upon his rights as guaranteed by the 14th Amendment to the United States Constitution. Upon his refusal to further testify, he could be held in civil contempt of court by the trial judge⁸ and ordered incarcerated.

However, the physician could effect immediate release from confinement by an application for a writ of habeas corpus. This action would establish a test case which would move to a higher court for a hearing and determination.

In this higher court, the basic rights of the physician guaranteed by the 13th and 14th Amendments to the United States Constitution could not be denied nor altered. As additional persuasive argument, the rulings of 10 state supreme courts which have previously heard this issue and have affirmed the right of the expert witness to receive reasonable compensation above and beyond that provided to a fact witness could be presented. These ten state supreme court rulings are as follows: Colorado,⁹ Florida,¹⁰ Illinois,¹¹ Indiana,¹² Iowa,¹³ Kansas,¹⁴ New Jersey,¹⁵ New York,¹⁶ Pennsylvania,¹⁷ and Rhode Island.¹⁸

With this information at hand, it is most likely that this appeals court of Hawaii would support the position of the physician, void the contempt citation of the trial court, and establish a judicial precedent for the state of Hawaii. This precedent would reinforce the customary practice of providing reasonable compensation to the medical expert witness by attaching the force of law to that practice.

REFERENCES

1. McNeil RJ: Medical Trial Technique Quarterly, 93-95, 1968
2. *Father Basil's Lodge Inc. v. Chicago*, 393, Ill. 246, 65 N.E. (2d) 805
3. *Pennsylvania Co. for Insurance v. Philadelphia*, 262 Pa. 439, 442 (1918)
4. *Appeal of Goodfader*, 367 P. 2d 472 (Hawaii 1961)
5. Hawaii Rev. Stat. Section 621-7 (Supp. 1973)
6. Hawaii Rev. Stat. Section 607-12 (Supp. 1973)
7. *Lucas v. Liggett & Myer Tobacco Co.*, 461 P. 2d 140 (Hawaii 1969)
8. Hawaii Rev. Stat. Section 621-4 (Supp. 1973)
9. *Lamont v. Riverside Irrigation District*, 498 P. 2d (1972)
10. *Tiedke v. Fidelity and Casualty Co. of N.Y.*, 222 So. 2d 206, 210 (1969)

11. Ill. Sup. Ct. R. 17-2 (5 Sept. 1961) (Impartial Medical Experts)
12. *Dills v. State*, 59 Ind. 15 (1877) (Additionally, the State Constitution states, "No man's particular services shall be demanded without just compensation.")
13. *Snyder v. Iowa City*, 40 Iowa 646 (1875)
14. *Womer v. Aldridge*, 125 P. 2d 392, 1942
15. *Stanton v. Rushmore*, 112 N.J.L. 115, 169 A 721
16. *Reda v. State*, 308 N.Y.S. 2d 558
17. *Evans v. Otis Elevator Company*, 403, Pa. 13 168A 2d 573 (1961)
18. *L'Etoile v. Director of Public Works of State of Rhode Island*, 153 A2d 173



Freedom of the Press, Henry Yokoyama and HMSA

Month in and month out, Dr. Henry Yokoyama is the star of this journal. Irrespective of the excellence or banality of the accompanying scientific articles, it seems everyone reads Henry. Some doctors read only Henry.

Not everyone likes what Henry writes—some people actually hate what he writes—but everybody reads his News & Notes.

Personally, I don't like his sexist and Polish jokes, but my husband does (he's Polish).

I hear that some doctor wrote all the way from South Africa, several times, complaining that Henry's lascivious stories had no place in a purported medical journal. One wonders why this doctor continues to read something that may displease him. (Do they have press freedom in South Africa?)

The HMSA hierarchy has recently taken exception to Henry's notes (HAWAII MEDICAL JOURNAL—Jan. 1980) on the November '79 HCMS meeting at which HMSA participated and was discussed.

I read Henry's notes after reading Mr. Al Yuen's letter of complaint to our editor, Dr. Arnold. (This letter is published elsewhere in this issue with Dr. Arnold's reply.)

Sorry, Mr. Yuen—I'm sure we don't mean to offend you and the HMSA. But what Henry was reporting was certain feelings that were expressed at the meeting. In a certain way, he caught the sense of the attitudes of some of the physicians attending.

In any case, HMSA will be with us for a long time, longer than Al Yuen, Henry or I will be around, I would think. Let's be friends, if we can.

As for freedom of the press, Henry has his, and Al Yuen is being invited to present a rebuttal. Since not all medical society members attended the November meeting some additional printed discussion should help to extend the thoughts

brought out at the meeting, on all sides.

D.R.J.

Sandoz Reviews HMJ

The Sandoz Pharmaceutical Company give awards for excellence to medical journals.

In its most recent deliberation and review, the Sandoz Company review group has described the HAWAII MEDICAL JOURNAL thusly:

"Graphically this small journal is a typographic gem. With a minimum of graphic efforts, it achieves style and distinction." Their scoring sheet makes us look like an Olympic gold medal winner.

Sandoz Company, we blush with pride. Thanks!

As Mr. Yuen has said about HMSA, "We must be doing something right."

P.S. The credit is mostly deserved by our stalwart managing editor, Paul Steward.

D.R.J.

Hooray For Our Side!

As dust settles over the Capitol and our legislators go home to stump, it is encouraging to see how much has been accomplished by medical political action.

The HMA gave positive support to several major pieces of legislation, and vigorously opposed many bills seen as detrimental to the community. We didn't win 'em all, but we were certainly successful in making known the views of our profession.

As usual, the "powerful (sic) Hawaii Medical Association" was represented by only a handful of fierce warriors on each issue. But we fielded more troops than last year, and many physicians who had never set foot in the Capitol found that the unfamiliar game of legislative persuasion could sometimes be fun. Others even found themselves exhilarated by the 2:00 a.m. cliffhangers that seem an inevitable part of the legislative process. Specialists who compete vigorously with one another by day, found themselves hammering out testimony together by night. Individual differences were overcome by the challenge of defeating a mutual adversary.

Medical faces are becoming familiar sights at legislative fundraisers, and it's exciting to see a traditionally aloof profession coming to grips with the realities of our political system. Like it or not, money means almost everything when it comes to influencing legislation. (With a burning zeal for preserving the public health, and 40 cents, you can get a cup of coffee!)

To all the individuals and specialty societies who helped, mahalo. To those who missed out, we hope you'll join us next year. It's exhausting and expensive, but exhilarating: a truly rewarding time of year. Next season the stakes are even

higher, for some terrifying mutation of the *unbelievably bad* State Health Authority Bill will surely rise from its shallow grave.

To paraphrase Will Rogers: "No one's health is safe while the legislature is in session." Yet thanks to the contributions and efforts of so many of you, your office personnel, and spouses, and thanks to the tremendous sacrifices of our officers, and the total support of the HMA staff, Hawaii's health seems safe once again. (At least, until next February.) Hooray for our side!

JMC

A Remarkable Record

Now and then something especially nice happens, for which we can all be grateful. One such event was the 1976 establishment of the Medical Claim Conciliation Panels, which were mandated by the legislature to review all medical tort claims prior to any court action.

The purpose of the legislation was to prevent non-meritorious claims from getting to court, and to encourage out-of-court settlement of claims found to be meritorious. Each panel consists of a chairperson appointed by the Chief Justice, and an attorney and a physician chosen by the chairperson from a list of volunteer panelists submitted annually by the Supreme Court and the Board of Medical Examiners.

So far, the panels appear to have been remarkably effective in fulfilling their purpose. During the year which ended last July, 53 hearings were held. In one-third of the cases (18) the physician was found liable, and 72% of these were settled. In two-thirds of the cases (35) no physician liability was found, and 82% of these were dropped or settled.

Thus, over 80% of the cases filed with the Medical Claim Conciliation Panels were dropped or settled without filing suit. Of cases where liability was found, 72% were settled out of court, often in exactly the amount recommended by the panels. It's a remarkable record: fewer than one case in five now makes it to suit. The savings in time, money, and anguish on all sides is enormous. We owe the Conciliation Panels our support and gratitude.

Perhaps it is time now for that medical liability insurance rate review hearing.

JMC



"I used to be crazy about men until I started working here!"

Help needed.

In the United States, one out of eleven women will develop breast cancer in her lifetime (in Hawaii the present rate is one in seventeen). With annual mammography screening for women at high-risk, the chances of finding cancers at the very earliest stages are greatly improved. Over time, morbidity, mortality, and quality of survival due to breast cancer will change for the better.

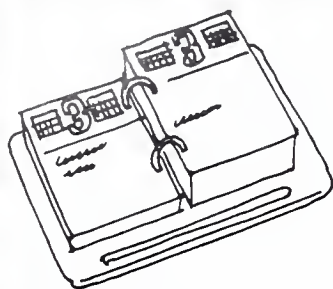
On Kauai, Wilcox Hospital, local physicians, community agencies such as the American Cancer Society, the Office of the Elderly and the Department of Health have organized in a cooperative effort with the Community Cancer Program of Hawaii (CCPH) to screen high-risk women for breast cancer via palpation, mammography and breast self-examination (BSE) instruction.

During the first year and two months of screening, 553 women completed the screening process. Three breast cancers were found. This represents a crude detection rate of 6.3 per 1,000 which can be compared with the Hawaii Tumor Registry 1978 crude incidence rate of 2.4 per 1,000 in the target population.

The proposal to extend this program to Maui and Hawaii has been held up by the National Cancer Institute (NCI); we need your letters of support.

COMMUNITY CANCER PROGRAM
of HAWAII

For further information call 548-8422 or write Director, Community Cancer Program of Hawaii, 1236 Louhala Street, Honolulu, Hawaii 96813.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani 1 Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.

4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.

6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m.
(Preventive Med.-Public Hlth. oriented.)

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Lectures
2. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
3. G. I. Conf., First Tuesday, 8:00-9:00 a.m.
4. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Endocrine & Metabolism Conf., First, Second, & Third Wednesdays, 7:30-8:30 a.m.
6. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
7. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
8. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
9. Surgical Conf., First, Second, Third, & Fifth Fridays, 12:45-1:45 p.m.
10. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.

7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
 8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. Tumor Conf., Second Monday, 7:30-8:30 a.m. Sullivan 4—Classroom.
- *3. Tumor Mortality & Morbidity Conf., Fourth Monday, 7:30-8:30 a.m., Sullivan 4—Classroom.
4. Renal Conf., First Monday, 1:00 p.m., Sullivan 4—Classroom.
5. EENT Meeting, First Tuesday, 7:00 a.m., Medical Board Room.
- *6. Department of Medicine Mtg., Second Tuesday, 12:30 p.m., Sullivan 4—Classroom.
7. Pulmonary Conf., Second & Fourth Wednesday, 12:30 p.m., Sullivan 4—Classroom.
8. Surgery Grand Rnds. First, Second, & Third Fridays, 7:30 a.m., Sullivan 4—Classroom.
- *9. Surgery M & M Conf., Fourth Friday, 7:30 a.m. Sullivan 4—Classroom.

*For SFH Staff Members Only.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS

- May 3-11, 1980 California Soc. of Anesthesiologists, San Mateo, CA. Held at Intercontinental Htl., Maui, and Hyatt Regency, Waikiki.
- May 4, 1980 Symposium on Human Nutrition, Lederle Labs/HMA. 6 hrs. Cat. I, & AAFP. Held at Ilikai Htl., Honolulu. Contact: CME Dept. HMA, 320 Ward Ave. Ste. 200, Honolulu, 96814 (808) 536-7702.
- May 10-17, 1980 Pediatric Workshop, Univ. So. Cal. 2025 Zonal Ave., L.A., CA 90033. Held at Royal Lahaina, Maui. 30 hrs. Cat. I.
- May 11-17, 1980 Modern Trends in Emergency Medicine, co-sponsored by National Emergency Services Inc.; HI Chapter of Emergency Physicians & John A. Burns Schl. of Med. CME Dept. (808) 947-8573 or (808) 948-7457.
- May 13, 1980 Osteoporosis Conference, held at Honolulu City & Cnty Employees Fed. Credit Union, 832 S. Hotel St., 3rd Flr., Honolulu. Sponsored by Straub. 1:00p.m.-7:00p.m. 6 hrs. Cat. I. Contact: Mary Hoffmeier, R.N. Proj. Coord., (808) 521-8269.
- May 23-31, 1980 Diving Medicine, 1980 Update. John A. Burns Schl. of Med., Honolulu. Held at Kauai Surf Htl. 35 hrs. Cat. I.
- July 26-Aug. 2, 1980 Cardiovascular Med & Surg., An Advanced Course. Stanford U Schl of Med., Stanford, CA 94305. 22 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI.
- July 28-Aug. 1, 1980 Med. Knowledge Self-Assessment Pgrm V. Am. Coll of Phys., 4200 Pine St., Philadelphia, PA 19104. Co-sponsor-J.A. Burns Schl of Med. U of H. 30 hrs. Cat. I. Held at Kuilima Hyatt Resort Htl., Honolulu. Contact: Dr. Irwin J. Schatz, (808) 546-2810.
- Aug. 9-Aug. 16, 1980 Ophthalmology—U of S. CA Schl of Med., 2025 Zonal Ave., L.A., CA 90033. 28 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI.
- Aug. 14, 15, 16, 1980 A Pan-Pacific Conf. on Tuberculosis in the 80s, Am Lung Assoc-spons. HI Thoracic Society. 245 N. Kukui St., Honolulu 96817. Held at the Ala Moana Htl., Honolulu.
- Aug. 16-Aug. 22, 1980 Stress & The Physician—Honolulu Med. Grp. Research Ed. Found., 505 So. Beretania St., Honolulu 96813 (808) 537-2211, ext. 751. 22 hrs. Cat. I. Held at Hyatt Regency Maui Htl., Maui, HI.
- Sept. 16, 23, 1980 Gastrointestinal Radiology. San Diego Radiology Res. & Educ Found., Box 2305, LaJolla, CA 92038. Cosponsor-Am Coll of Radiology. Held at Maui Surf Htl. 4 days-30 hrs. Cat. I.
- Oct. 7-11, 1980 Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. I. Contact: Mary J. Ryals, P.O. Box 2305, LaJolla, CA 92038(714)459-9787.
- Oct. 13-17, 1980 124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8-12noon. Contact: HMA office (808)536-7702 for further info.

* * *

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.

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Friday, March 7, 1980
HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Lum, Hindle, Goto, Chinn, Iaconetti, Kam, Don, Lambeth, Chun-Hoon, Lumeng, Shirasu, Bruce, Cahill, Fong, McNamee, Wigle, Fu, Mills, Char, Dang, Sia, Simmons, Hellreich, Uemura, Chang, Fryer, Mr. V. Thomas Rice, Mrs. Nancy Simmons, and Mrs. May Kim. HMA staff present were: Messrs. Won, Leineweber, Mmes. Kendro, Chang, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 6:05 p.m.

MINUTES:

The minutes of the previous meeting were approved as amended.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of February 29, 1980 which indicated that HMA membership totaled 923 in comparison with February 1979 when membership totaled 899.

REPORT OF THE TREASURER:

The December 1979 financial statement was reviewed in detail and approved subject to audit.

On behalf of the HCMS, Dr. Calvin Kam recommended that membership problems may warrant consideration of scheduling dues payments in installments.

ACTION:

It was moved, seconded, and passed to refer this matter to the Finance Committee for study and report to the Council.

Auxiliary President Mrs. Nancy Simmons reported that its leadership met with Treasurer, Dr. Hindle, to discuss the Auxiliary's finances for forthcoming years. An informational presentation was made by Mrs. Simmons to review for Council members the Auxiliary's goals and objectives, programs, and projected budgets up to 1985.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Public Affairs: Dr. McNamee reported that a study was conducted to monitor calls made to Tel-Med

on weekends. The study indicated that Tel-Med receives approximately 300 calls a day. Inasmuch as Tel-Med is HMA's major public education effort, the Public Affairs Committee recommended that Council consider approval of funds (approximately \$1,300) to increase Tel-Med's hours of operation to include Saturdays from 12 noon to 8 p.m.

ACTION:

It was moved, seconded, and passed to approve funds to increase Tel-Med's hours of operation to include Saturdays from 12 noon to 8 p.m.

In the TV-Radio area, Dr. McNamee reported that viewership of HMA's TV series, "Your Body, Your Mind," has increased this year. The Committee feels that the increased interest can be attributed to promotional efforts undertaken this year. Funds for promotion have been solicited and obtained from community resources, however, it was pointed out that the Committee presently lacks adequate funds to continue placement of advertisements in TV Guide to promote the remainder of the series. The TV-Radio Committee requested that Council consider approval of funds (approximately \$1,500) for eight additional advertisements.

ACTION:

It was moved, seconded, and passed to approve an appropriation of \$1,500 for eight additional advertisements in TV Guide for promotion of the series.

B. Convention: The Pacific Beach Hotel was announced as the site for the 1980 Annual Meeting. Dr. Herbert Uemura reported that HMA is working closely with the Medical Education Committee of the UH School of Medicine to develop a scientific program.

Dr. Bell reported that HMA had received a letter from AMA proposing AMA regional meetings to be held in Hawaii in conjunction with HMA Annual Meetings on an every-other-year basis (1981, 1983, 1985, etc.) provided that both parties are satisfied with the outcome.

ACTION:

It was moved, seconded, and passed to hold HMA Annual Meetings in conjunction with AMA Regional Meetings in 1981, 1983, 1985, etc. (every-other-year basis) provided that both parties are satisfied with the outcome.

C. Cancer Commission: Council reviewed the slate of nominations for terms expired on the Commission. There were no additional nominations from the floor.

ACTION:

It was moved, seconded, and passed to elect the following physicians to the Cancer Commission:

American Cancer Society,	
Hawaii Division	Carl Boyer, M.D. (1982)
Department of	
Health	John Chalmers, M.D. (1982)
Hawaii Medical	
Association	Drake Will, M.D. (1982)

A recommendation was made that the composition of the Commission be reviewed.

ACTION:

It was moved, seconded, and passed that the Bureau of Research and Planning review the composition of the Cancer Commission, with

the idea that if any changes are to be made, they be submitted to the HMA House of Delegates.

D. Medical Services: Dr. William Dang reported that an announcement was made recently by the Health Care Financing Administration (HCFA) regarding a procedure coding system based on AMA's CPT-4 and a uniform claim form developed by AMA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Associations, which are being adopted for Federal programs. In view of this development, Council felt that it should reconsider its December 1979 decision to publish a Hawaii CPT.

ACTION:

It was moved, seconded, and passed to postpone printing of a Hawaii CPT until Council is able to consult with the Fee Survey Committee Chairman.

E. Legislation: Dr. George Goto presented a status report on health related legislation. Mr. Won, Dr. Hellreich, and Dr. Simmons discussed with Council some of the areas of primary interest to HMA such as (1) a bill which proposes the establishment of a Hawaii Health Authority, (2) chiropractic, and (3) Medicaid reimbursement. Members were encouraged to review HMA's testimonies and to attend public hearings.

F. Medical Malpractice Insurance Crisis Committee: Dr. Philip Hellreich reported that a Medical Malpractice Insurance Crisis Committee was formed as a result of a resolution passed by the 1979 HMA House of Delegates. A survey of members and non-members is being conducted to gauge the medical community's support in requesting a rate review hearing before the State Insurance Commissioner under the Administrative Procedures Act.

G. Public Health: Drs. Thomas Cahill and Calvin Sia presented recommendations from the School Health Committee.

ACTION:

It was moved, seconded, and passed to adopt the following recommendations:

- (1) That HMA re-emphasize the need for the DOH and DOE to contact the primary care physician for any child who is handicapped or has health problems to follow through with, to enable the primary care physician to identify treatment needs as necessary.**
- (2) That HMA supports Senate Bill No. 711 which delineates the functions between the DOH and DOE in diagnosis, evaluation, and management of the handicapped child. (The DOH will be primarily involved in the 3-5 years old developmentally delayed children, while the DOE will be primarily responsible for special education of the 6-20 years old. The DOH and DOE will assist each other in the total care and management of all handicapped children 3-20 by a memorandum of agreement.)**
- (3) That HMA supports the concept of the School Health Services Branch being located within the Department of Health.**

The School Health Committee will form a sub-committee of orthopedists, general practitioners, pediatricians, and neurologists to review the checklist utilized in determining the PT and OT needs of

handicapped children.

Dr. Cahill mentioned that the Sports Medicine Committee is exploring the development of a uniform reporting form for sports injuries. The Cancer Committee is continuing to explore the concept of guidelines for cancer management. At its last meeting, the committee was given an update on CCPH activities.

H. Health Service and Care: Dr. Donald Char presented HMA's reactions to the Hawaii State Health Plan, Third Edition, which were prepared by the Community Health Care Committee.

I. Medical Education: Dr. Nadine Bruce reported that annual CME records of credits will be sent out by June. It is anticipated that the computer will provide assistance in this area next year. A recommendation was made that Council adopt policies for CME recordkeeping.

ACTION:

It was moved, seconded, and passed that HMA retain medical education data on programs accredited by HMA for all licensed physicians.

It was moved, seconded, and passed that HMA will provide cumulative information on CME only to members. There were three opposing votes.

J. EMS: Dr. William Dang reported that the EMS Program has just completed a 1203 Federal grant application for a training program on the neighbor is-

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lands. The DOH-HMA contract is pending.

K. Jail Health Care Committee: Dr. Walter Chang reported that the Jail Health Care Committee held its first orientation session for physicians. Mrs. Becky Kendro briefed the Council on the AMA-sponsored training workshop for jail health care project coordinators which she had attended in Chicago.

L. Computer: Mr. Jon Won reported that membership records have been transferred to the computer abstract form, with emphasis now on non-member information. In March BME programs will be installed. It is hoped that the computer will become operational in April.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Calvin Kam reported that the HCMS has re-established the Medical-Legal Committee with the Hawaii Bar Association, with a view toward reviewing and updating the Medical-Legal Inter-professional Code. Dr. Kam mentioned that the Society has been asked by CCPH to name a representative to serve on a subcommittee for the Melanoma Skin Cancer Program. HCMS held its first membership meeting on March 4 which focused on current issues such as legislation, Medicaid, and RVS/CPT.

B. Hawaii: Dr. James Lambeth reported that recent activities of the Society included a meeting with the HMSA medical director and several meetings with

state legislators. In approximately three weeks, the Society will hold another meeting on the subject of acupuncture.

C. Maui: Dr. Andrew Don reported that the Society sent petitions regarding Medicaid reimbursement to all Maui legislators. The Society will be participating in the upcoming Wellness Celebration on Maui.

ADJOURNMENT:

The meeting adjourned at 9:45 p.m.



Hawaii Academy of Family Physicians' Newsletter

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We boast two new members this month, both transfers from mainland chapters. **Kathleen R. Malaney** from Iowa now resides in Kaneohe, and **Janette D. Sherman** moved from Michigan to Paia, Maui.

Drs. Boone and Koch were reelected to three year Active memberships. Dr. Koch resides presently in New Mexico but expects to relocate on Molokai shortly.

Dr. James Tsuji will attend the AAFP State Officers Meeting in Kansas City May 3-4. Dr. Tsuji is President Elect of our Chapter.

Last call for our next **dinner meeting**, at the home of **Dr. and Mrs. Garton Wall**, at 2667 Tantalus Drive. Eminent rheumatologist, Dr. Peter Singleton, is one of the guest speakers. Please mail or phone your reservations no later than April 21 to **Marlies Farrell**.

Residency Progress Notes: A unique honor was bestowed on one of our resident affiliate members, **Dr. Harold Timboe**, now in his second year of training at Tripler AMC. Dr. Timboe was named a recipient of the Mead Johnson Award of \$1200, recognizing him as one of the outstanding Family Practice residents in the U.S. Special ceremonies were held on April 3, at which the award was presented by commanding General Huyck. President **Pat Dietrich** represented HAAP and Nancy Kickeretz, Mead Johnson. Proud witnesses were **Lt. Col. Robert Todd**, chief of Family Practice at Tripler as well as members of Harold's family including his parents who were visiting from the mainland. The award was based on Harold's outstanding medical credentials, his character and integrity and his proven leadership abilities. Congratulations Harold!

Much less happy news was received at the U.H. Family Practice Program based at Kaiser, with word

on Maui. They're headed for a European honeymoon . . ." (don chapman Feb 15)

A *Star Bulletin* editorial points out that the fee schedule for the Medicaid program has not been changed since 1975, although reimbursement for other programs such as Medicare has been raised 36% over the last four years. "The state is committed to provide medical care for the indigent. But that commitment becomes seriously eroded when we permit reimbursements to doctors to fall far behind the rate of inflation." The editorial points out that the alternatives would be that fewer doctors would be willing to treat Medicaid patients and those willing to accept them would compensate for their losses by charging their other patients more.

A statewide medical examiner's system is being advocated by the HMA, the Hawaii Society of Pathologists and the UH Med School Dept of Pathology. **Alvin Majoska**, the only certified forensic pathologist in the state feels that the bill is not needed and could even damage Honolulu's current medical examination program. Others, however, feel that there is an immediate need to upgrade the medical examiner system statewide . . .

The Hawaii Emergency Physicians Association has filed suit in Circuit Court for collection of additional Medicaid fees. The suit names Andrew Chang, director of DSSH as defendant and claims that Andrew in 1975 froze the minimum fees paid to physicians in violation of federal law . . .

Crusading Pediatrician **Wayne McKinny** reported that Kaimuki High School officials were just plain irresponsible when they failed to call police and seek medical help for an 18 year old Laos student who was beaten in a hijacking attempt at school. It was the second Laos boy he had treated in two weeks. Wayne said, "I wonder how long people are going to put up with the weakness and irresponsibility that some of

our public school administrators show when there is violence and injustice in our schools."

HMSA announced that its Community Health Program has two new members viz Central Medical Clinic Inc, and the Haleiwa Family Medical Center, thus raising the total to 13 health centers in Hawaii. Other medical groups under the program are the Medical Arts Clinic in Wahiawa and Waialua, the North Shore Clinic in Kahuiku, the Straub Clinic and Hospital, the Vineyard Medical Clinic, the Fronk Clinic, and the Waianae Coast Comprehensive Health Center. Under the program, the members make a moderate payment for each visit, then they are covered in full for both regular hospital and office visits as well as physical checkups, immunizations, and maternity and well baby care . . .

The Physician's Protective Association elected **William Davis** president, **Sorrell Waxman** first VP, **Claude Caver**, second VP and membership chairman **Glenn Hayashi**. **Doris Jasinski** was held over as secretary and **John Roberts** as treasurer. New board members include **Glenn Hayashi**, **Gordon Ontai** and **James Oda**. Holdover board members are **Francis Au**, **John Corboy** and **Samuel Gresham**. The association provides legal defense funds for members in malpractice actions . . .

Physician speakers at a one-day symposium on April 13 at the Sheraton-Waikiki on "Medical Ideas: Progress and Business for the '80s" sponsored by the American Association of Medical Assistants, Hawaii Society, included **Roger Ogata** (Treatment with Bees) **Frank Ceccarelli**, **John McDougall**, **Sorrell Waxman**, and **Marc Shlachter**.

Visiting Professors

Queen's medical director **Dennis Meyer** admirably introduced Kenneth Melmon, visiting Professor and Chairman of Dept of Medicine, Stanford Med School as "a utility infielder" because of his versatility in pharmacology and medicine . . . So our utility infielder showed up informally in faded jeans and sport shirt and treated us to a most enlightening lecture on hypertension . . .

"I don't know what to do for diabetes . . . I don't know what to do for osteoporosis . . . I don't know what to do about cholesterol levels . . . But I do know what to do for high blood pressure . . . Most people over age 50 with BP's around 90 diastolic should be treated." Three months ago, I could not have made this statement, but that was changed by the recent editorial in the *New England Journal* . . . A control group was sent to private practitioners and an experimental group sent to a Hypertensive Disease Clinic . . . The outcome of the study is unequivocal . . . The Hypertensive Disease Clinic lowered the BP to 80 or lower . . . Max Smith in his Hypertensive Cooperative Study showed very clear efficiency and using old fashioned drugs . . . There is no evidence that new drugs are needed at present . . . To treat or not to treat . . . 23 to 27 million people are at risk . . . What drugs to choose and why combinations are more effective with the exception of thiazide diuretics . . . Diuretics lower peripheral arterial resistance . . . When using diuretics, we get into major changes with total body Na and K . . . Extensive diuresis will affect patient compliance (Reason for avoiding furosemide and ethacrynic acid) . . . Diuretics help control BP, but it should be on the basis of lowering peripheral arterial resistance . . . Determinants of Blood Pressure ($BP = C.O. \times PVR$): 1. Cardiac Output (venous capacitance) 2. Peripheral arterial resistance 3. Blood Volume . . .

No one has found any deficiency in the sympathetic system and the baroreceptors . . . Drugs will lower peripheral arterial resistance and inhibit sympathetic system. Thus, the therapeutic objective is to be close to sympatholytic . . . ie, the therapeutic strategy is a. reduce peripheral arterial resistance and b. reduce the sympathetic reflex . . .

Thiazides: are the first line of defense because they work (40% of patients); are safe and potentiate other drugs . . . Problems with thiazides: a. Increases cholesterol levels eg, Type I or II hyperlipidemia, and b. decreases HDL . . . Hyperuricemia is not a problem since the relative pool size of uric acid remains unchanged with thiazides . . .

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Hydralazine: lowers total peripheral resistance, increases cardiac output and to some extent lowers arterial pressure . . .

Classes of Antihypertensive Drugs: A. Dilates Capacitance Vessels (Sympatholytic) eg, Reserpine, methyl dopa, guanethidine, ganglionic blocking agents, clonidine . . . Re, Compliance: "We did physicals on the Washington Redskins and found many of them hypertensive . . . So we started them on reserpine (They loss their will to kill . . . which was obvious watching them perform on TV . . . So we shifted to guanethidine . . . (Now they had the will to kill, but they couldn't get there.) Finally the coach thanked us and asked us to stop the drugs . . . So you see, compliance is very important)"

Propranolol: It's a "dirty" drug . . . maybe that's why it is so useful . . . Its effects on renin secretion is unknown . . . As physicians we generally underestimate in our treatment of hypertension . . . The heart rate should be lower than before treatment . . . If the resting rate is the same as in pretreatment, then think of non-compliance or that the liver is blocking . . . Then increase the dose of propranolol . . .

B. Decreases Arteriolar Resistance: eg, Thiazides and diazoxide; hydralazine, methyl dopa, reserpine.

Drug Combinations: The advantages: a. Lower doses than with single drugs, think of the anatomical sites where the drug works in chosing drug combinations . . . Drug combinations should not be acting on the same site . . . My preference is to start with a diuretic, then added propranolol to the diuretic; and finally hydralazine to propranolol and diuretic . . .

"40% of the patients are seeing two doctors when being treated for hypertension . . . Watch out for interaction of drugs, eg, with birth control pills, phenothiazines, etc . . ."

Depression In Private Practice

Robert Gerner, assistant prof of the Dep of Psych, UCLA, was here in early April and lectured on depression. Herein are notes therefrom:

Depression is "a pathological disorder of the brain; not a 'reaction' or normal state . . ."

Unipolar Depression (shows no episodes of mania or hypomania). Duration 1-2 years in the treated and longer in the aged . . . Incidence 15% in women and 7% in men . . . Research criteria include 1. Dysphoric mood (eg, depression, helplessness, emptiness) 2. Clusters of symptoms (eg, appetite loss or increase, sleep disturbance, loss of energy) 3. Duration: 2 weeks plus. 4. Impaired functioning . . .

Depression can be classified into Retarded Depression and Agitated Depression:

	<i>Retarded Depression</i>	<i>Agitated Depression</i>
Age of Onset:	Younger—30's—recurrent	Older—50-60's
Family Hx:	Often positive	Non-genetic

Premorbid:	Normal	Obsessions
Sleep:	Usually hypersomnia; not restless	Insomnia
Appetite:	Increased wt., but no interest in food	Anorectic
Libido:	Decreased	Decreased
Activity:	Fatigued, listless	Nervous energy, anxiety, wiping hands, but fatigued, wringing hands
Mentation:	Loss concentration	Decreased concentration
Thought Content:	Morbid, pessimistic, negativistic	Morbid, pessimistic, negativistic, ruminating, worried
Somatic:	Menstrual irregularity	Multiple somatic complaints
Both:	Irritability—marriage problems; guilt, suicidal thoughts, crying spells, diurnal change (improves toward evening); loss of interest in previously pleasurable activities	

Causative Factors: Environment and Biological Predisposition; neuroendocrine abnormalities of the limbic system including the hypothalamus

Other Causes:

1. Iatrogenic: 2° to drugs eg, reserpine, Aldomet, guanethidine, Clonidine, rebound from stimulants, and more recently from Tagamet and propranolol.

2. Endocrine, CNS, Pernicious Anemia, post-viral encephalopathy, dementia, neoplasm, alcoholism

Pathophysiology: metabolites of serotonin and norepinephrine

Agitated Depression:	Low serotonin High MHPG
Retarded Depression:	High serotonin Low MHPG

Treatment of Unipolar Depression:

Retarded Depression: Use noradrenergic tricyclics (low MHPG) eg, Desipramine, Imipramine

Agitated Depression: Sinequan (low serotonin) Elavil

Clinical Tricyclic Regimen: Raise 50mg q 3-4 days till 300mg level . . . Leave on for months (approx 6 months) Then taper off . . . 80% response. (Use lower dosage in orientals and geriatric patients)

Tricyclic Side Effects:

- 1. Anticholigergic: Key symptoms: dry mouth, constipation, urinary hesitancy
Rx: Urecholine 10-25 mg tid
- 2. Sympathetic: Symptoms: tachycardia, tremors, palpitations, sweating
Rx: Propranolol 10-20mg tid
- 3. Cardiovascular: Orthostatic hypotension No Rx . . . Change antidepressant
Decreased conduction time: Increased PR, QRS, QT intervals. (All tricyclics have quinidine-like effect)



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Summary of treatment of Depression:

Medication for 3-6 months, then taper off ¼/mos after recovery . . . If recurrence of symptoms, then psychotherapy . . . Psychotherapy may be useful to reduce stress or conflict in patient or family

Ddx of Agitated vs Retarded Depression: Sleep pattern Underlying cause being decreased MHPG in Retarded vs decreased serotonin in Agitated Depression

Drugs of Choice:

Agitated Depression: Tofranil, Pertofrane

Retarded Depression: Elavil, Sinequan

In Aged, use either Tofranil or Sinequan since these are safer with less anticholinergic or sympathetic side effects.

Ddx Depression vs Dementia: CAT Scan. San Francisco's Dr Feinstein found 15% abnormal CAT scans in patients over 70. (esp dilated ventricles unilateral or bilateral)

Hors De Combat

The Kahuku Community Hospital board of directors finally voted to drop a hospital bylaw forcing physicians to carry medical malpractice insurance—a requirement that had led to the departure of two physicians and leaving the emergency room understaffed by a physician several times a week . . .

While there is pending legislation to create a statewide medical examiner's office, the two physicians in the Honolulu Medical Examiner's Department, acting medical examiner **Richard Wong** and forensic pathologist **Alvin Majoska** are both planning to retire soon. UH School of Medicine professor of pathology **John Hardman** warned, "If they don't find somebody to replace those men, then the city is going to start asking the hospital pathologists to fill in. Most private pathologists don't want to do that. The work is time consuming, it interferes with their other schedules, they have to go to court for lengthy and sometimes highly publicized interrogations. If the private pathologists are called on by the city for consultative work, I have a feeling the city will be getting hit with some high fees. Since the city is probably going to end up spending more money the other way, they should look for a forensic pathologist to do the work, or at least a good young pathologist willing to undergo forensic training."

Advertiser staff writer James Dooley has investigated the coroner system on the different islands and has discovered a strange situation on Maui where there is a brand new under utilized morgue at the state run Maui Memorial Hospital, but the coroner's physician **Kenneth Haling** has to use the embalming rooms of the three private mortuaries and no one knows why except that the mortuaries bill the county \$100 per autopsy . . . Apparently no one has asked the state for permission to use the hospital morgue. On Kauai, an average \$250 is paid the hospital used and to **Rex Cough**, a pathologist under county contract to serve as coroner's physician . . . On Hawaii, **Moon Soo Park** and two other pathologists under county contract perform their autopsies at Hilo Hospital. The Hospital does not charge for use of its morgue facilities. In Honolulu, the City and County of Honolulu owns and operates its own morgue facility in Iwilei. Not so on Maui . . .

"Whether you win or lose has nothing to do with morality. It's a matter of lobbying" (**Dr John Corboy**, ophthalmologist). The ophthalmologists and optometrists don't see eye to eye . . . Both groups are locked in an intense lobbying battle to determine the fate of a bill designed to give optometrists the right to use "diagnostic" drugs on their patients . . . **Shigemi Sugiki** testified, "The term diagnostic drug is misleading because drugs do not make diagnoses. It is still the medically trained examiner who makes the diagnosis. Medical knowledge of the complex drug and organ interactions is necessary and only acquired through a medical education, specialized training and most importantly, hospital training."

The 19th Hole . . .

The jogger passing the tennis courts in Ala Moana found a stray tennis ball. He stuck it into his shorts and continued on. He caught up with a girl buddy also jogging who noticed the prominent bulge. She asked curiously, "What's that?" "That's a tennis ball." "Sure hope it doesn't hurt like a tennis elbow!" she said sympathetically . . . (As told by our golfer friend **Alan Luning**)

A distraught woman made an appointment with a sex counselor because her marriage had lost its appeal . . . The counselor suggested, "You should try variations in position for a starter. What is your usual position?" "Well, I lie on my right side." "Then try lying on your left side," he suggested. "But then, I won't be able to watch the TV," she protested . . . (As told by our real estate appraiser friend, **Walter Loo** . . .)

The night of the wedding is sometimes confession time for newlyweds . . . The husband confessed, "Honey, I never told you, but I'm a golf addict." The wife replied, "Since we are clearing our consciences, I also have to tell you that I'm a hooker." "Honey," he reassured her, "That's no problem . . . You simply take a more open stance . . ." (Another **Alan Luning** joke . . .)

Elected, Appointed, & Honored

The Garden Island ran a "Citizen of the Seventies" poll and though JoAnn Yukimura was the overwhelming leader, three Kauai physicians were among those named. The late Samuel Wallis and a Jeremy Harris tied with the next highest vote. Burt O. Wade and William Goodhue were also among those named . . .

Kenneth Fujii of Kauai was honored at a mahalo party on Mar 1 at the Kauai Surf Convention Center. **Peter Kim**, a longtime colleague, spoke of Kenneth's many years of unselfish service, of having always responded to the needs of his patients with understanding and sensitivity. "He has the respect of all of his colleagues and we wish him a happy and long retirement."

The Honolulu SERTOMA (Service to Mankind) Club elected **Jack Scaff** as one of 15 Freedom Award winners for 1980 . . . **Stewart Matsumoto** was elected to fellowship in the American College of Cardiology . . . **Sharon Bintliff** and **Calvin Sia** were among Hawaii's 12 delegates to the White House Regional Conference on Families, July 10 through 12

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in LA. . . **Kent Davenport, James Oda** and **Masao Takai** have been inducted into the American Academy of Orthopedic Surgeons at their annual meeting in Atlanta . . . The Hawaii State Chapter of the American Red Cross awarded **Sharon Bintliff** a special Certificate of Appreciation for administering cardiac massage to **Ward Russell** when he had a heart attack in Kapiolani Park in May 1979. . .

Life in These Parts

Ralph Cloward, peripatetic internationally known neurosurgeon, was once again called on to perform a rare neck surgery. This time it was on a 23-year-old man from Istanbul, Turkey, who was first sent to West Germany's Hamburg University and then transported here in a cast and accompanied by a West German neurosurgeon and a neurologist. The surgery took 4 hours and Ralph had to remove the posterior section of the atlas and then crush the dislocated odontoid process when removing it. Once before in 1965 a 16-year-old Polish girl, Malgorzata Downarawicz was brought here from Krakow and Ralph removed a neck tumor. She is now a mathematics professor with a doctorate . . . **Hans Arnold**, the West German neurosurgeon explained, "He's world famous as a specialist in cervical spine surgery and that's why we came."

"Ya Gotta Have Heart: Moderate consumption of beer (4½ cans daily) apparently reduces the chances of heart disease, says **Dr Katsuhiko Yano**, assoc director of the Honolulu Heart Study at Kuakini Hospital since 1965. Before you have a drink to celebrate, however, please note that Dr Yano says, 'alcohol increases the chances of dying from stroke or cancer' . . . Yano also says Japanese men in Hawaii are far healthier than Japanese men in Japan or California and healthier than Caucasian men here and on the Mainland. The rate of heart attacks among Japanese men is higher here than in Japan, but much lower than for Caucasians. But the stroke rate is much higher in Japan and among Caucasians . . ." (Gleaned from don chapman's column)

Letters continued from page 79

We will continue in our objectives and goals to provide the people of Hawaii with the finest health care coverage at reasonable costs—whether the Hawaii Medical Association wishes to support these efforts is their decision to make. More than 60% of Hawaii physicians are participating with HMSA to provide medical care at reasonable costs to their patients, 530,000 of whom are our members.

Finally, as one of your long term "ANGELS" we are dismayed at the frequent references to HMSA in very negative tones and frivolous style in several issues of the JOURNAL which I believe is demeaning to the stature of the JOURNAL and the Hawaii Medical Association. We respectfully ask that you reconsider your future representation of these issues.

Sincerely,
A. H. YUEN
Executive Vice President

I have read your letter about Dr. Yokoyama's report of the meeting at which HMSA discussed problems of mutual interest with members of the Honolulu County Medical Society, and I must say that you have a point.

Though I did not attend the meeting, I am assured by some who did that Dr. Yokoyama's reporting was accurate and reflected clearly the dissatisfaction expressed by many doctors with HMSA.

What it failed to reflect, and in all fairness should have reflected, was the responses of HMSA to these dissatisfactions. HMSA has indeed been one of our "Angels" over the years and although this has not had and did not have any effect on

our treatment of HMSA in the Journal's pages, we certainly do not think it right for us to deal unfairly with you. You are hereby offered equal space—or up to a page if you like—to enumerate and explain HMSA's responses to the questions that were raised. You can find out from Mr. Paul Steward what the deadline is for the next issue, but we will bend it a little for you if necessary.

HARRY L. ARNOLD, JR. M.D.
Editor

Dear Dr. Corboy:

Your editorial in the February, 1980 HAWAII MEDICAL JOURNAL on Relative Morality is invalid. You are comparing "apples to oranges." Mr. Takushi, as the public record indicates, paid the workers for work that was actually performed. This is not the same as billing for services not rendered.

The solution to the doctor's problem would be for the physicians to threaten to quit unless they were compensated properly.

Thank you,
DAVID K. LIVINGSTONE, M.D.

You raise an interesting question. According to newspaper accounts and the Civil Service Commission report, the timesheet entries were in fact fraudulent. King's contention was that the overtime was never worked, while Takushi's initial response was that the overtime was worked, although not at the times listed on the sheets. This particular point was never clarified because Takushi refused to testify.

In any case, there seems no argument that the timesheets did not correctly represent factual events. To my knowledge, there is no public record of the fact that the work was actually performed. My point, however, was simply that the records were intentionally falsified in both the Takushi and Medicaid cases, to spend money for what were rationalized to be appropriate ends. I'll concede this may be a comparison of red apples with green apples.

The only significant difference, I believe, between the two cases was the issue of direct personal gain. The physician's office received money as a result of fraud, whereas Takushi did not (apparently) receive money as the result of his fraud.

Your "solution to the doctor's problem" is currently being tested in the Legislature. If compensation remains below 50% of fees and you were one of only two GP's in a rural town, and your practice was 98% Medicaid, would you quit?

Thanks for writing. I hope you'll share your thoughts again.

JOHN M. CORBOY, M.D.

Our "Angels"

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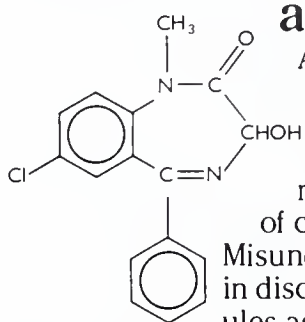
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Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

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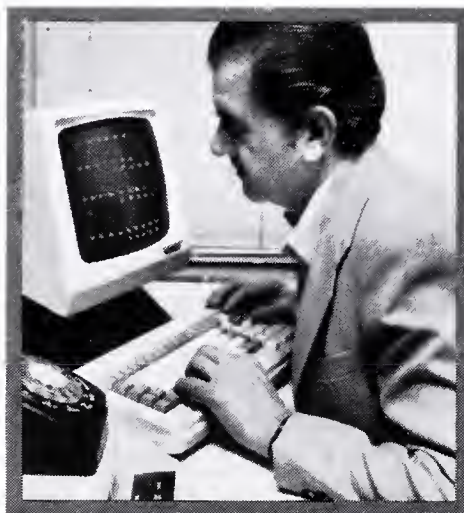
Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy.

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What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they



learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms.

Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, et al: *Am J Hosp Pharm* 31: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders,

possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

do's

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

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its action. Usual precautions indicated in patients
severely depressed, or with latent depression, or with
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Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported. Should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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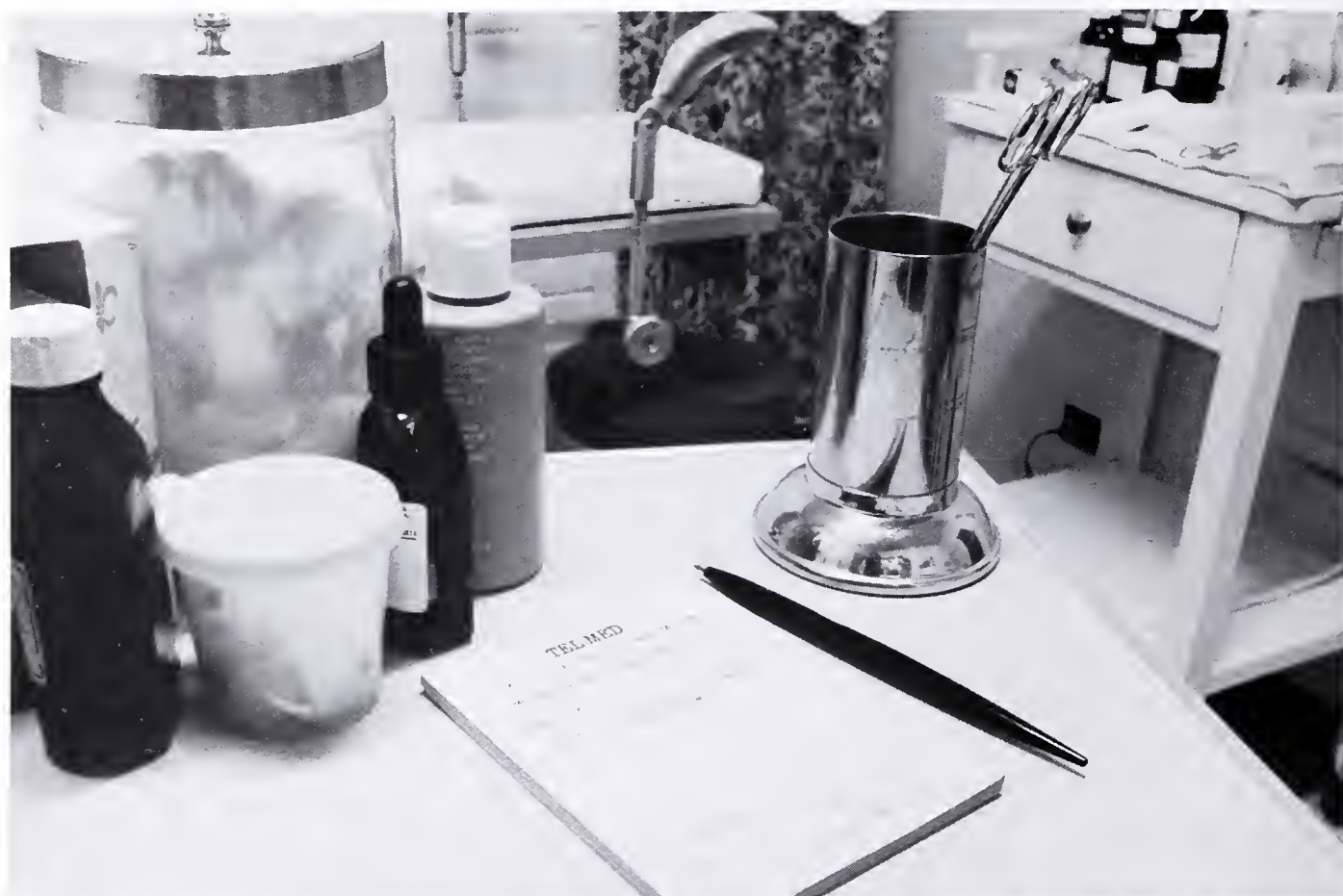
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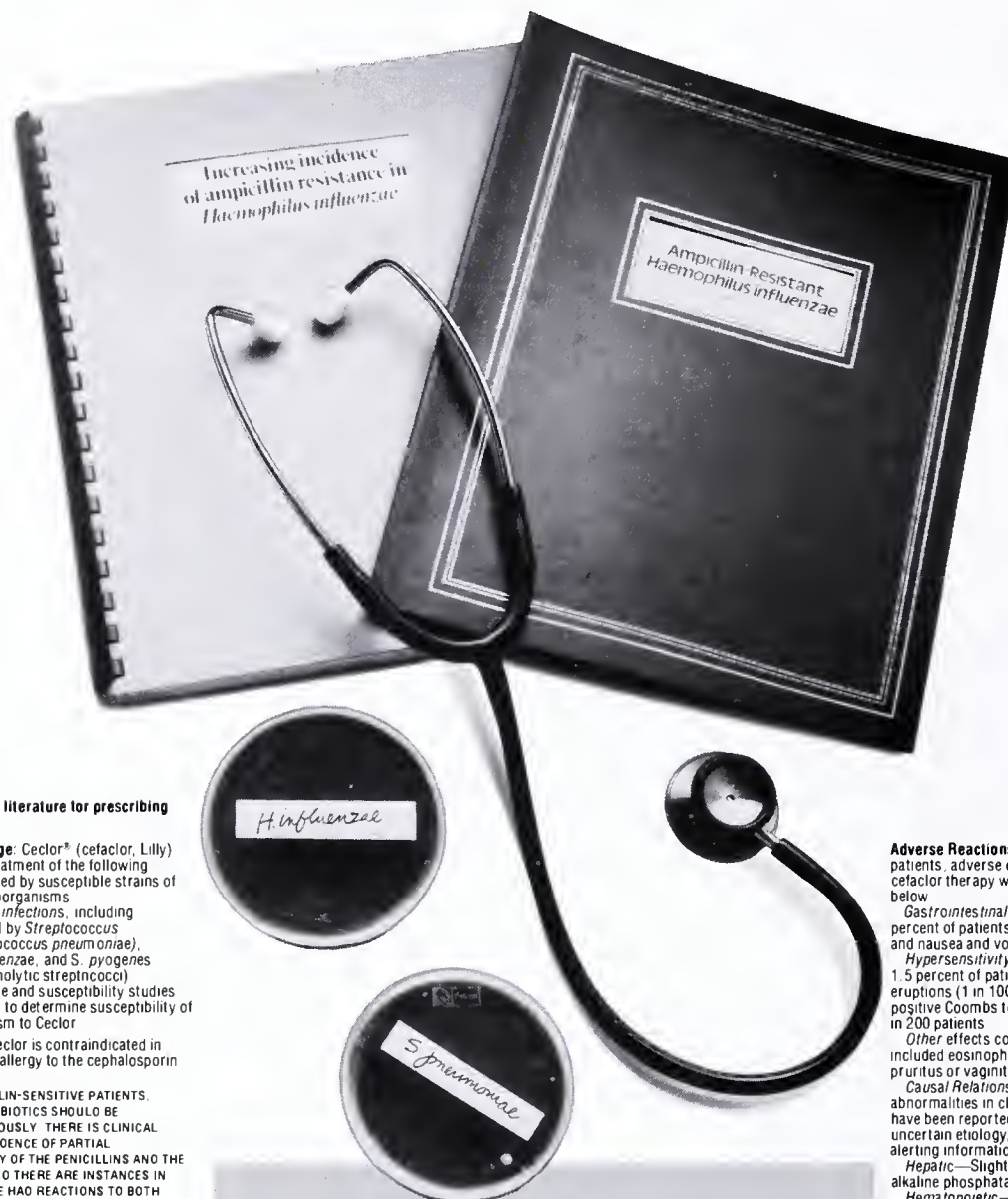
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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II, 880, Washington, D.C., American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487, New York, John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
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000482

Dysbarism in Paradise

KENNETH W. KIZER, M.D., M.P.H., *Honolulu*

● *Almost everyone in the diving community is aware that there is widespread diving activity in Hawaii and, consequently, that there are numerous diving casualties. In fact, more cases of dysbarism occur in Hawaiian waters than in any other location in the United States. Despite the high incidence of decompression sickness and air embolism that occurs in the Hawaiian Islands, little has been written about it previously.*

The preliminary findings of an analysis of dysbarism cases treated by the U.S. Navy Undersea Medicine Service at Pearl Harbor during 32 months—January, 1977 to August, 1979—are reported herein. The 157 cases reported upon here are cases which were discharged from the recompression chamber with a diagnosis of either decompression sickness or air embolism. With the exception of two cases of hypobaric decompression sickness treated in 1977, all of the cases occurred in divers. Not included in this series are numerous other cases which were given a “trial of pressure” to delineate the cause of symptoms which questionably represented dysbarism, cases of round window rupture which were recompressed to rule out possible inner ear decompression sickness, and cases of carbon monoxide poisoning, refractory osteomyelitis, radio-osteonecrosis, surgical air embolism, and other non-diving diseases which were treated with adjunctive hyperbaric oxygen therapy. The same amount of information was not available on every case, so different denominators have been used to calculate the percentages of the various factors analyzed.

Treatment Facilities

Until recently, all cases of dysbarism occurring in Hawaii have been treated by the U.S.

Navy at Pearl Harbor, Oahu. The other hyperbaric chambers located on Oahu—e.g. the University of Hawaii facilities at Kewalo Basin and Makai Pier in Makapuu—are either used exclusively for research or are non-operational. There are no plans at this time to open a civilian-operated hyperbaric treatment facility on Oahu. A little over a year ago a monoplace chamber was acquired by Maui Memorial Hospital in Wailuku, Maui. It has been used to treat a few cases of bends, as well as for administering hyperbaric oxygen therapy, but most of the serious symptom decompression sickness is still referred to the Navy, either immediately or after initial recompression in the monoplace chamber while transportation to Oahu is being arranged. More recently, a double-lock chamber has become operational at Kona Hospital in Kealahou, Hawaii. In addition, a double-lock chamber has been very recently installed at Kauai Veterans Memorial Hospital in Waimea, Kauai.

Table 1 shows the temporal distribution of cases treated at Pearl Harbor. There is no clear pattern, either by month of the year or by day of the month. If the number of cases treated on the neighbor islands (Maui and Hawaii) are added to the number of cases treated by Pearl Harbor this year (1979), more cases have been treated so far this year than by this time in any previous year. A record number of cases may be treated in 1979. (Number not available.)

The number of cases treated in any given time period should be related to the number of divers in the water during that period, which should be determined by water and weather conditions, types of diving being done, whether it is a holiday or if schools are in session, and similar factors. Unfortunately, this type of information is not readily available, and no way exists to predict accurately when to expect the greatest number of diving accidents. Such information would be very useful for planning diving safety programs.

U. S. Navy Undersea Medicine Service, Pearl Harbor, Hawaii.

Presented September 15, 1979 at the Annual Meeting of the North Pacific Chapter, Undersea Medical Society, Inc., San Francisco, California.

Accepted for publication January, 1980.

TABLE 1—*Distribution by month*

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1977 (n=71)	11	8	6	2	1	3	7	6	8	9	9	1
1978 (n=47)	5	1	7	4	8	1	0	1	6	3	7	4
1979 (n=39)	3	3	4	4	12	3	3	7	—	—	—	—

Locale

The distribution of cases according to the island nearest which they occurred is shown in

TABLE 2—*Distribution by island*

	OAHU	MAUI	KAUAI	HAWAII	OTHER
1977 (n=71)	71%	15%	7%	7%	—
1978 (n=47)	79%	6%	6%	6%	3%
1979 (n=39)	74%	10%	8%	—	8%
total (n=155)	74%	11%	7%	5%	3%

Table 2. The numbers are fairly consistent from year to year and show that three-fourths of all cases occur in waters surrounding Oahu. Even with the new hyperbaric chambers operating on the neighbor islands, it is expected that Pearl Harbor will remain very active in treating dysbarism in the future. The “other” category included cases transferred from Molokai, Kure and Midway Atolls (about 1,100 miles from Oahu), Palau, Tonga, and other islands of the South Pacific. It is relevant to note, however, that most of the cases occurring in Micronesia, Melanesia, and Polynesia are treated locally. In addition to providing actual treatment of cases, the Navy Undersea Medicine Service at Pearl Harbor also provides telephone consultation service for the treatment of diving casualties throughout the Pacific Basin.

Military Personnel

The distribution of cases according to affiliation with the military is shown in Table 3. The percentage of the case population represented by military personnel and their dependents

TABLE 3—*Distribution by military status*

	CIVILIAN HUMANITARIAN	MILITARY DEPENDENT OR RETIRED	ACTIVE DUTY MILITARY
1977 (n=71)	79%	6%	15%
1978 (n=47)	62%	6%	32%
1979 (n=39)	74%	3%	23%
total (n=157)	73%	5%	22%

roughly approximates their proportion of the population of the Hawaiian Islands. Although slightly over-represented in the total study population, the cases in military personnel and their dependents consist almost entirely of mild decompression sickness and asymptomatic omitted decompression. A few of these cases were in hospital corpsmen who rode as inside tenders on treatments. (Generally, these were lengthy and complicated treatments.) Two cases of air embolism occurred in non-diving submarine personnel who were undergoing submarine escape training.

Sex

Table 4 shows the distribution of cases by sex. Dysbarism appears to be a man’s disease in Ha-

TABLE 4—*Distribution by sex*

	MEN	WOMEN
1977 (n=69)	97%	3%
1978 (n=47)	87%	13%
1979 (n=39)	95%	5%
total (n=155)	94%	6%

waii. Although 20% to 25% of the American diving population is estimated to be women¹, the proportion of women divers may be higher in Hawaii. The disparity regarding the number of dysbarism cases treated in women is probably due to the fact that the majority of cases treated at Pearl Harbor are Hawaiian commerical fishermen and black coral divers, who are essentially all men. The proportion of women sport divers treated may more closely approximate their percentage of the sport diver population. However, if women are really more susceptible to decompression sickness, then one would expect that they would constitute a greater percentage of the sport diver case population^{2,3}. Unfortunately, the figures necessary to calculate these things are not available at this time.

Age

The breakdown of cases by age is shown in Table 5. Although a significant number of cases

FIG. 1—The Submarine Escape Training Tank on the Submarine Base at Pearl Harbor. This is the site of the 2 main recompression chambers that have been used by the Navy to treat Hawaii's bends cases ever since World War II. This tower is one of only 3 of its kind in existence and has been used to train submariners and divers submarine escape techniques since the 1930's. Photo courtesy of U.S. Navy.



TABLE 5—*Distribution by age*

	10 - 19	20 -29	30 - 39	40 - 49	OVER 50
1977 (n=69)	7%	39%	36%	13%	4%
1978 (n=47)	4%	62%	19%	11%	4%
1979 (n=39)	3%	44%	45%	5%	3%
total (n=155)	5%	47%	34%	10%	4%

occurred in middle-aged individuals, more than 80% of the cases happened in young adults. Most of the patients who were left with significant residual damage after recompression treatment were in this young group. This fact becomes socially significant when one considers that potentially productive members of society are damaged at a time when their prospects for productivity are greatest.

Levels of Training

Table 6 shows the level of training of the case population. Several points are noteworthy about

TABLE 6—*Distribution by training**

	SPORT	U.S. NAVY OR COMMERCIAL	OTJ/NONE
1977 (n=61)	69%	16%	15%
1978 (n=46)	76%	13%	11%
1979 (n=39)	70%	15%	15%
total (n=146)	71%	15%	14%

*highest level of training

this aspect of the study group. First, the significant number of cases occurring in untrained individuals—a group consisting entirely of commercial fishermen and black coral divers—underscores the need for diving training and safety programs to reach all segments of the community. Even though a diver certification card is supposedly required to get scuba tanks filled, this rule is variably enforced in Hawaii. In addition, some of the commercial fishermen and black coral divers have their own air compressors

or have other access to a compressor. Thus, some individuals have no need to attend a formal diving course. These divers receive all of their training “on the job,” and they are often taught by relatives who were similarly (un)trained.

Second, several of the sport diver cases were in NAUI-trained diving instructors who apparently felt that they do not have to adhere to the safe diving principles promulgated by NAUI and other diving associations. In fact, the only fatality in this series was in a NAUI instructor. It is not known how active these individuals are in teaching NAUI diving classes.

Third, the number of cases occurring in Navy-trained divers and commercial divers who have graduated from an official commercial diving school is misleading. (This does not include the “Hawaiian commercial” diver.) The level of training was recorded as the most rigorous training a diver had ever received—not by current diving affiliation. Several patients were listed in this category who had been trained by the Navy but who were no longer in the military and who were sport diving contrary to safe practices taught by the Navy. Also, the general mildness of the military diving related cases was previously noted.

Fourth, many of the stricken divers who had received formal sport diver training appeared to have little or no knowledge of how to use the decompression tables or repetitive dive tables, nor of fundamental safe diving principles.

Case Population

Table 7 describes the case population according to their length of diving experience. Although one might expect that experience would teach respect for the decompression tables and ingrain safe diving practices, this has not been the case. Actually, the opposite is seen. A steady increase in the case population is seen with increasing length of experience.

Of bends cases, 11% reported having more than 20 years of diving experience; there are very few divers in Hawaii who have been diving for over 20 years. This again represents the contribution of the Hawaiian diving fishermen and black coral divers to the case population. Considering their flagrant disrespect for all established decompression procedures, it is surprising that

TABLE 7—*Length of diving experience*

	0 - 3 MO	3 MO - 1 YR	1-2 YR	2 - 5 YR	5-10 YR	OVER 10 YR
1977 (n=63)	3%	5%	11%	19%	24%	38%
1978 (n=46)	13%	11%	—	22%	30%	24%
1979 (n=37)	3%	3%	5%	24%	22%	43%
total (n=146)	6%	6%	6%	21%	26%	35%

these divers do not get hurt more often than they do. It is possible that they have empirically developed certain diving methods that offer some protection against the bends, although this is mere speculation at this time. However, the high incidence of dysbaric osteonecrosis in this population (perhaps as high as 65%) demonstrates that their diving practices are not benign.⁴

The percentages of working divers listed in Table 8 are probably accurate only for 1979.

TABLE 8—Distribution of cases by type of diving

	SPORT	WORK
1977 (n=69)	62%	38%
1978 (n=47)	62%	38%
1979 (n=39)	38%	62%
total (n=155)	56%	44%

Prior to this year there was a tendency to indicate every non-military diver as a sport diver, which grossly underestimated the number of Hawaiian commercial divers—diving fishermen, black coral divers, tropical fish collectors and others. Fig. 2 lists the various types of underwater work prevalent in Hawaii. It is estimated that over 70%

FIG. 2—Types of underwater work in Hawaii

- BLACK CORAL DIVERS
- COMMERCIAL DIVING FISHERMEN:
 - Gill net fishing
 - Spearfishing
 - Octopus fishing
- TROPICAL FISH COLLECTING
- SHELL AND CORAL COLLECTING
- SPORT DIVING INSTRUCTORS
- DIVE CHARTER BOAT GUIDES
- UNDERWATER CONSTRUCTION
- SHIP HULL MAINTENANCE AND REPAIR
- SCIENTIFIC AND RESEARCH DIVING
- MILITARY DIVING OPERATIONS:
 - Scuba
 - Conventional hardhat
 - Explosive ordnance disposal
 - Mixed gas (heliox)
 - Submarine escape training

of the total case population were working divers, both commercial and military, the largest single group being diving fishermen.

TABLE 9—Distribution according to discharge diagnosis

	TYPE I DCS	TYPE I AND TYPE II DCS	TYPE II DCS	CEREBRAL AIR EMBOLISM	ASYMPTOMATIC OMITTED DECOMPRESSION
1977 (n=71)	28%	11%	44%	11%	6%
1978 (n=47)	40%	13%	26%	9%	12%
1979 (n=39)	33%	16%	33%	10%	8%
total (n=157)	33%	13%	37%	10%	7%

*Type I DCS is "pain only bends", while type II DCS represents all of the serious forms of decompression sickness—e.g. neurological, pulmonary, inner ear, and cardiovascular.

The distribution of cases according to the discharge diagnosis given upon release from the recompression chamber is listed in Table 9. Half of all the dysbarism cases treated were serious symptom decompression sickness; a third of the cases were pain-only bends. The percentage of cerebral air embolisms seems consistent from year to year at about 10% of all dysbarism treated.

The most common circumstances preceding the occurrence of an air embolism was running out of air at depth. Depending on the year, this situation happened in 25 to 50% of all cases of air embolism.

Types of Decompression Sickness

Table 10 shows the breakdown of decompression sickness (DCS) into pain-only or type I,

TABLE 10—Distribution of decompression sickness

	TYPE I DCS	TYPE I AND TYPE II DCS	TYPE II DCS
1977 (n=59)	34%	14%	52%
1978 (n=38)	52%	16%	32%
1979 (n=32)	41%	19%	40%
total (n=129)	41%	16%	43%

and serious symptom or type II DCS, as well as combinations of both. Of all the DCS cases, 59% involved serious symptoms; type I and type II symptoms coexisted in 16% of the cases. This approximates what has been previously reported.⁵

Bizarre cases having various combinations of spinal cord, cerebral, inner ear, and/or cardiorespiratory involvement are frequent. It has been reported that pain-only bends constitutes 70% to 90% of all decompression sickness occurring in divers.^{6,7,8,9} That implies that many cases of DCS are not being treated in Hawaii. Indeed, many of the victims report having had pain-only bends several times for every time that they seek treatment, which is often only for neurologic symptoms.

The predilection of decompression sickness to affect the lower thoracic and lumbar spinal cord is well recognized. In this series, over a third of all DCS cases and almost two-thirds of serious symptom DCS cases presented with lumbar spinal cord involvement, as shown in Table 11. Numbness, tingling, and weakness of one or both legs were the most common symptoms in these cases.

TABLE 11—Percentage with lumbar spinal involvement

	% OF ALL DCS	% OF TYPE II DCS
1977 (n=25)	42%	64%
1978 (n=10)	26%	56%
1979 (n=12)	38%	63%
total (n=47)	36%	62%

Strenuous exertion at depth is believed to predispose one to decompression sickness. Table 12 gives the distribution of cases according to the level of exertion of the dive reported by the diver. Several of the divers with severe DCS,

TABLE 12—Level of exertion of the dive

	MILD	MODERATE	STRENUOUS
1977 (n=51)	53%	10%	37%
1978 (n=41)	61%	15%	24%
1979 (n=34)	41%	27%	32%
total (n=126)	52%	16%	32%

some of whom were left with marked residual deficits, reported working very hard at depth, e.g., swimming against a strong current, or hauling heavy, fish-laden nets to the surface.

Omitted Decompression

Table 13 lists the estimated omitted decompression for the symptomatic DCS cases, based on the U.S. Navy decompression tables. The dive profile of many of the cases was so erratic and confused that it was impossible to calculate a precise amount of omitted decompression. The figure estimated probably underestimates the true decompression debt in many cases.

TABLE 13—Estimated omitted decompression for symptomatic decompression sickness

	NONE	0-4 MIN	5-14 MIN	15-29 MIN	30-59 MIN	60-119 MIN	120-239 MIN	OVER 240 MIN
1977 (n=56)	23%	4%	12%	12%	9%	20%	16%	4%
1978 (n=37)	35%	11%	11%	8%	5%	5%	22%	3%
1979 (n=31)	16%	10%	19%	16%	10%	10%	3%	16%
total (n=124)	25%	7%	14%	12%	8%	13%	15%	6%

The large number of stricken divers who reported missing no required decompression is almost certainly erroneous. It is grossly out of line with what is expected from the Navy tables. Most likely, some divers were not truthful when reporting their dive profile for fear of appearing naive or stupid. Similarly, some divers probably did not know their real depth or bottom time because the depth gauge or dive watch which was worn was not used properly or malfunctioned or because these items were not worn. A few of these cases were of inside tenders on treatments, who should have been "clean" according to the decompression tables. Because of these latter cases, all inside tenders on a non-extended Treatment Table 6 are now put on oxygen for at least the last 30 minutes of the treatment; a longer time on oxygen is used if the Treatment Table was extended. In addition, some of the patients who reported no omitted decompression had other significant negative dive factors.

About 4% of all the cases missed over 300 minutes of decompression, and a couple of divers omitted over 400 minutes. The most surprising aspect of this is that the severity of the presenting symptoms did not necessarily correlate with the amount of missed decompression. Several of the diving fishermen who omitted more than 120 minutes of decompression presented with pain-only DCS, while some of the worst neurological cases were seen in sport divers who had missed less than 10 minutes of required decompression. This may be a manifestation of acclimatization to the hyperbaric environment, although a physiologic explanation for this phenomenon is not available at this time.⁶

The estimated time interval between surfacing and the onset of DCS symptoms is shown in Table 14. (Air embolism cases are not included.) The few patients who had the onset of symptoms prior to surfacing (generally between 30 feet and the surface) are included in the group who had symptoms immediately upon surfacing. More than half of the cases noted their initial symptoms less than 10 minutes after surfacing, while over three-fourths of the cases experienced symptoms within one hour of surfacing. About 93% were symptomatic by 6 hours after the dive. This tendency for the early onset of symptoms seems to be related to the large decompression debts incurred by the divers as well as the severity

TABLE 14—Time interval between surfacing and symptom onset for symptomatic DCS

	00-10 MIN	10-30 MIN	30-60 MIN	1-3 HR	3-6 HR	6-24 HR	OVER 24 HR
1977 (n=55)	67%	7%	7%	11%	2%	5%	—
1978 (n=36)	38%	17%	17%	6%	8%	8%	6%
1979 (n=31)	35%	26%	13%	10%	13%	—	3%
total (n=122)	51%	15%	11%	9%	7%	5%	2%

TABLE 15—Time interval between symptom onset and beginning of treatment for symptomatic decompression sickness and cerebral air embolism

	LESS THAN 1 HR	1-6 HR	6-12 HR	12-24 HR	OVER 24 HR
1977 (n=63)	10%	44%	32%	6%	8%
1978 (n=41)	5%	54%	19%	15%	7%
1979 (n=34)	6%	50%	6%	23%	15%
total (n=138)	7%	49%	22%	13%	9%

of the decompression sickness. Several of the "commercial" divers reported that they noted symptoms after a second or third dive and that these symptoms disappeared during the ensuing surface interval or during descent on the next dive, but recurred in more severe form after subsequent dives. Interestingly, these divers did not interpret their initial symptoms as a reason to stop diving or to seek treatment.

Reasons for Delay

The time interval between the onset of definite symptoms and the beginning of treatment is shown in Table 15. Typically, the diving fishermen and black coral divers had the longest delays in seeking treatment. Reasons for this delay include attempting in-water recompression—which was universally ineffective and generally caused a worsening of the original symptoms; attempting what some people have nicknamed as "Hawaiian treatment" (aspirin and Primo beer—emphasizing the beer); attempting treatment by breathing surface oxygen—which is carried by many of the commercial divers and is reported as variably effective; denying the significance of the symptoms; difficulty in arranging transportation to the Pearl Harbor recompression chamber from the neighbor islands; or failure of non-diving medical personnel to recognize decompression sickness.

Table 16 shows the average time interval between the onset of symptoms and the beginning

TABLE 16—Average time between symptom onset and beginning treatment

1977	7.4 hr.
1978	8.0 hr.
1979	9.2 hr.*

*excluding two cases of several days

of treatment for each of the study years. The numbers are not significantly different. Since recompression treatment is more effective the sooner it is instituted,¹⁰ there is good reason for opening hyperbaric treatment chambers on the neighbor islands.

Nonetheless, much of the delay in getting appropriate treatment is not because of the distance to the hyperbaric chamber. Rather, it is due to the reluctance of afflicted divers to seek treatment. There continues to be a need to emphasize to these wayward divers the need to seek early and established modes of treatment.

Recompression Results

A significant number of divers were treated more than 24 hours after the onset of their symptoms. Almost all of these were type I DCS cases. In general, recompression significantly relieved their symptoms. One patient from Molokai presented 6 days after the onset of his symptoms and obtained almost complete relief of his shoulder pain after recompression treatment.¹¹

The overall amount of relief achieved by recompression treatment, which included adjunct-

TABLE 17—Amount of relief achieved by recompression treatment

	COMPLETE	SUBSTANTIAL	MODERATE	MINIMAL
1977 (n=67)	61%	24%	5%	10%
1978 (n=41)	46%	37%	5%	12%
1979 (n=36)	67%	14%	14%	5%
total (n=144)	58%	25%	7%	10%

tive drugs and fluids when appropriate, is shown in Table 17. The majority of cases obtained complete relief of their symptoms, although 17% remained substantially affected by their disease. It has been observed, though, that paraplegia and similar neurologic damage resulting from decompression sickness does significantly better in the long term than similar neurologic injuries resulting from other causes, e.g., trauma or stroke. Thus, a very aggressive treatment program, often including hyperbaric oxygen therapy in the initial stages, is indicated for these cases. It also has been observed that some of the patients who are left with residual symptoms and who resume diving often return with another episode of DCS, frequently involving the same neurologic distribution, leaving them more severely damaged.

Although U.S. Navy Treatment Table 5 is occasionally used to treat pain-only bends among local divers, i.e., when depth, bottom time, and other similar variables are known with certainty, it has been the general experience of the Undersea Medicine Service that at least Treatment Table 6 is needed to treat either type I or type II DCS in civilians because of their usually large decompression debt and long delay in seeking treatment, as well as uncertainty about their reported diving profile. Typically, one or more extensions of Treatment Table 6 are needed also. U.S. Navy Treatment Table 5 has been used for treating asymptomatic omitted decompression and type I DCS in military divers doing military diving and in aviators.

Returning to Diving

Prior to discharge from the recompression chamber, all patients are advised about returning to diving. Although the advice is frequently not heeded, there seems to be good reason at this time for recommending that patients who have suffered an air embolism or serious decompression sickness with permanent residual damage should never dive again, nor work in any compressed air environment. Following treatment for type II DCS in which all symptoms resolve, either during treatment or soon thereafter, a 6 month period of no diving after the complete resolution of all symptoms is recommended. A thorough examination by a neurologist is also recommended before these individuals return to diving. No diving for at least 4 weeks after all pain resolves is recommended after being treated for type I DCS. In addition, it has been my policy to restrict diving for 3 days after treatment for asymptomatic omitted decompression.

Acknowledgment

I am indebted to the other members of the Undersea Service at Pearl Harbor for allowing me to review cases they have treated. In addition, I am grateful for the cooperation and assistance of LT(jg) K. Bassett, USN, Director, Submarine Escape Training Tank, Pearl Harbor.

The opinions and assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

REFERENCES

1. Costelloe VJ, Nutt NB: "Getting women to dive." *Addendum to the Proceedings of the Tenth International Conference on Underwater Education*, pp. 34-40. NAUI Diving Association, Colton, California. 1978.
2. Bangasser SA: "Medical Profile of the Woman Scuba Diver." *Proceedings of the Tenth International Conference on Underwater Education*, pp. 31-40. NAUI Diving Association, Colton, California. 1978.
3. Bassett BE: "Decompression Sickness in Female Students Exposed to Altitude During Physiological Training." A paper presented at the 44th Annual Scientific Meeting of the Aerospace Medical Association. 1973.
4. Wade CE, Hayashi EM, Cashman TM et al: "Incidence of dysbaric osteonecrosis in Hawaii's diving fishermen." *Undersea Biomed Res* 5: 129-135, 1978.
5. Erde A, Edmonds C: "Decompression Sickness: A Clinical Series." *J Occup Med* 17: 324-328, 1975.
6. Hills BA: *Decompression Sickness—The Biophysical Basis of Prevention and Treatment*, pp. 29-47. John Wiley and Sons. New York, New York. 1977.
7. Rivera JC: "Decompression Sickness among divers: An analysis of 935 cases." *Milit Med* 129: 314-334, 1964.
8. Bennett PB, Elliott DH: *The Physiology and Medicine on Diving and Compressed Air Work*, 2nd edition, pp. 471-495. Williams and Wilkins Company, Baltimore, Maryland. 1975.
9. Strauss RN: *Diving Medicine*, pp. 63-83. Grune and Stratton, New York, New York. 1976.
10. Bayne CG: "Acute Decompression Sickness: 50 cases without a failure." *Undersea Biomed Res* 5 (Supplement): 19, 1978.
11. Kizer, KW and RT Larsen. "Delayed Treatment of Type I Decompression Sickness." *Pressure* 9: 1-2, Jan-Feb 1980.

Boardsurfing and Bodysurfing Injuries Requiring Hospitalization in Honolulu

LAURETTE A. CHANG* and CLARENCE E. McDANAL, JR., M.D.,† *Honolulu*

We reviewed the medical records of board and bodysurfing patients admitted from 1973 through 1977 to the Queen's Medical Center in Honolulu for inpatient care. There were a total of 49 inpatients, including 26 board surfers, 21 body surfers, and 2 innocent bystanders on the beach who were not engaged in surfing activities but were struck by stray body surfers.

Of the board surfers 54%, were in the 15-20 year age group, whereas 76% of the body surfers were over 20 years of age, predominantly in the 26-30 year age group. There were no deaths among these patients admitted to the hospital and only one incident of salt water aspiration with near-drowning.

In 1973, a peak of 23 patients were hospitalized from surfing accidents. Of these, 17 were board surfers, with 7 sustaining nasal fractures. No nasal fractures were reported in the other 4 years.

Types of Injuries

All board surfing injuries except 3 were due to trauma from a surfboard. The 3 exceptions were coral lacerations and abrasions after the riders lost control of their boards and were thrown against the rocks. Six head-injured patients were hospitalized for observation, including 2 who required surgery for depressed skull fractures. Enucleation of an eye was performed on a surfer who accidentally fell on the tip of his surfboard, ramming it into his left orbit.

Blunt trauma to the chest and abdomen occurred in 3 persons. One patient was hit by a surfboard and received a traumatic pneumothorax, right hemothorax, and a fractured rib. A second person was struck by a surfboard which fractured four ribs and his liver, necessitating a partial hepatectomy. The other abdominally injured person suffered multiple abdominal abrasions. He was struck by a wave which caused him to lose control of his board, resulting in his being hit by the surfboard and being dragged over the rocks.

All musculoskeletal injuries had good immediate rehabilitation results with surgery, except for a 15-year old boy who fell from a board, scraped his leg on coral, lacerated himself with the board and completely transected his common peroneal nerve. The nerve was realigned, but on discharge he still had loss of motor function.

Body Surfing Hurts

The body surfers sustained serious spinal injuries, including 9 spinal fractures and one cervical spine contusion. One patient with a spinal fracture suffered paralysis with permanent loss of function, while another experienced slow return to ambulation. The others were initially paralyzed but soon recovered and suffered no observable deficit or paralysis. Of 2 head injuries, one, a basal skull fracture, the other a frontal contusion. Musculoskeletal injuries totaled 11, consisting of one shoulder dislocation with ulnar nerve dysfunction, 2 acromioclavicular joint separations, and 4 knee injuries with torn ligaments. Of these patients, 2 had, in addition, torn medial meniscus. The other 4 musculoskeletal injuries were fractures of the lower extremities.

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Relaxation Skills Training— An Alternative in the Treatment of Headache

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● *Headache is certainly a very common ailment. It is estimated that 40 million Americans suffer chronic recurrent headaches.¹ The Pontypridd Headache Study,² which contained a good sampling from all walks of life, found that 63.5% of men and 78.4% of women surveyed had suffered from headache in the year previous to the survey. A total of 29.9% of men and 43.5% of women reported their headaches as having been "quite severe." In their survey of a non-clinical population, Ziegler et al³ found that 82.6% of men and 84.2% of women had suffered from headaches at some time in their lives. "Disabling," "severe" headaches were reported by 40.9% of men and 50.2% of women.*

Despite its limited success, the treatment of headache has usually been pharmacological. More than \$4 billion is spent annually on over-the-counter headache remedies.¹ In addition, analgesics, ergot alkaloids, sedatives, or tranquilizers are frequently prescribed by physicians. In recent years, however, there has been growing interest in the psychophysiologic aspects of headache and the use of behavioral modification as a method of approach for the treatment of headache.⁷⁻¹⁵ The present study is an attempt to assess, in a clinical setting, the relatively simple use of relaxation skills training as a treatment for headache.

Methods

For instruction in relaxation skills, patients were referred to the Health Education Center of Straub Clinic and Hospital. The method of relaxation skills employed is based on the progressive relaxation technique of Jacobson.⁴ The patient views an automated filmstrip and listens to an audio-cassette tape program that depicts an

adult demonstrating the technique of progressive muscle relaxation.⁵ The program runs for 25 minutes, during which the patient is instructed in and asked to actively perform 14 exercises which involve tensing and then relaxing various muscle groups throughout the body. As they tense their muscles, an appreciation for the sensation of muscle tension is gained. By contrast, as they release that tension, patients are able to feel the sensation of relaxation and thereby "learn to relax." After the audiovisual presentation, a professionally skilled health educator conducts an interview with the patient. The patient's work life, home life, recreational pursuits, dietary habits, and exercise activities are discussed. At the conclusion of the session, the patient is given a booklet which contains pictures and a text derived from the audiovisual program. With the aid of this booklet, the patient continues to practice the relaxation exercises at home. The entire session, including the viewing of the audiovisual program and the post-program interview, usually lasts about an hour.

Initially, the full set of exercises is practiced on a regular basis twice daily and at any time the patient begins to feel an imminent headache. As they gain relief, patients may adjust their practice of the technique to suit individual needs. The goal is for the patient to learn to relax, and not the rigid performance of a set of exercises. Should patients feel it necessary, a "take home" cassette-tape recording of the verbal relaxation instructions from the audiovisual program is available to purchase or borrow until they feel proficient with the technique.

In an attempt to gauge the effectiveness of the relaxation skills technique, a questionnaire was sent to those patients who had been referred for relaxation skills training because of headache. Once the study was underway, ques-

*Third year medical student, University of Michigan Medical School. Study supported in part by the Pacific Health Research Institute. Accepted for publication October, 1979.

tionnaires were mailed to patients on a regular basis, starting four weeks after their session with the health educator. The patients were asked to respond to questions regarding their practice of the relaxation skills, and their opinions as to whether or not they felt the practice of the relaxation skills was helping them with the problem.

Also, in order to obtain a profile of these patients, a survey was made of their clinical records. Areas of interest included sex, age, diagnosis at the time of referral, and whether or not the record contained any mention of stress as possibly contributing to the headache problem.

Results

Of the 80 questionnaires sent out, 40 (50%) were returned. Four patients were eliminated from the study because they were not suffering primarily from headaches. In 3 of the 4 patients it was possible to identify their questionnaires, thereby allowing them to be definitively removed from the study. The final patient did not present to the clinic with headache, but for evaluation of a possible seizure disorder. All remaining respondents listed headache as a primary problem.

Of the 37 patients, 5 (14%) were men, 30 (81%) were women, and 2 did not respond to the question. In terms of age, 5 patients (13%) were under 20 years, 15 (41%) were between 20 and 29 years, 8 (22%) were between 30 and 39 years, and 3 patients (8%) were in each of the categories of 40 to 49 years, 50 to 59 years, and 60 years and over.

All 37 patients indicated that they had practiced the relaxation skills exercises after learning them in the Health Education Center. Some 15 patients (41%) reported that, at the time of the survey, they were no longer practicing the exercises.

In response to a question concerning the frequency of their past or present practice of relaxation skills, 12 patients (32%) reported practicing twice a day, 11 patients (30%) practiced once a day, 5 (14%) practiced about 2 times per week, 3 (8%) practiced once a week, 2 (5%) gave no response.

A total of 33 patients (89%) felt that the exercises were helpful in reducing their "body tension," while 4 patients (11%) did not. Another 32 patients (86%) found the exercises helpful in reducing the amount of their "mental tension," 4 patients (11%) did not, and one patient (3%) did not respond to the question.

When asked to respond concerning overall feelings about the program, 17 patients (46%) felt it was "very successful," 17 patients (46%) felt it was "moderately successful," 2 patients (5%) indicated they were using (or had used) the program but found it to be of no help, and one patient (3%) felt the program was not successful.

Of the 15 patients who, at the time of the survey, were no longer practicing the relaxation skills technique, 6 found the program very successful, 7 found it moderately successful, and 2 felt the program had not been of any help. Patients were asked to list the ways the program had helped them; both patients who no longer practiced the relaxation skills, as well as those still doing so, reported relief from headache and related complaints.

Records of all the patients to whom the questionnaires were mailed were reviewed. Because of insufficient data, 4 were thrown out. Of the 76 patients, 16 (22%) were men and 60 (79%) were women.

The diagnostic categories used were those of the A.M.A. Ad Hoc Committee on Classification of Headache.⁶ Under the diagnosis of vascular headache of migraine type were 8 patients (11%). Muscle-contraction headache was diagnosed in 43 (57%). Combined headache (vascular and muscle-contraction) was the diagnosis in 14 cases (18%). One patient (1%) appeared under each of the categories of headache of nasal vasomotor reaction and non-migrainous vascular headache. Five patients (7%) were found to have had headaches of delusional, conversion, or hypochondriacal states. One patient (1%) was diagnosed as having post-traumatic headache. No definite diagnosis could be found for 3 patients (4%).

Mention of stress, from such sources as work, school, family, marriage, or personality was made in 34 cases (45%). In 29 cases (38%), no mention of stress factors could be found. Possible cases of stress as a contributing factor to headache were noted in 13 (17%). This was based on either a physician's note stating that he suspected stress as a factor, or when a patient conceded that it might be possible.

Discussion

Several studies have examined the question of muscle relaxation as a therapy for muscle-contraction headache. In their study of 10 subjects, Fichtler and Zimmermann⁷ showed muscle relaxation to have a significant effect on reducing the duration and intensity of headaches, and in decreasing the amount of interference with activities. In his study of 5 subjects, Wickramasekera⁸ found a decline in the frequency and intensity of headaches after muscle relaxation training. Studies by both Chesney and Shelton,⁹ and Haynes *et al*¹⁰ showed relaxation skills training to significantly decrease headache frequency when compared to a control group. In a study by Tasto and Hinkle,¹¹ 6-week followup records of a week's headache activity showed 4 of 6 subjects to be headache-free; each of the other 2 subjects had suffered only one headache. Cox *et al*¹² found that a relaxation technique group had reduced their medications significantly as com-

pared to a drug placebo group. Warner and Lance¹³ studied 13 patients with muscle-contraction headache, 8 patients with migraine headache, and 4 patients with combined vascular and muscle-contraction headache. A followup done 6 months after relaxation skills training showed that, of the 17 patients suffering from muscle-contraction headache, all but 3 reported a substantial decrease in headache frequency. Some 12 patients were able to either eliminate or reduce their medication intake by more than 50%. Of the 12 patients suffering from migraine headache, 2 became headache free, and 6 had a greater than 50% reduction in the frequency of their headaches. Of the 12 patients, 9 were able to decrease their medication dosage by more than 50%.

The use of muscle relaxation for the treatment of migraine headache has also been reported in a case study by Lutker.¹⁴ After muscle relaxation training, the subject became headache-free, whereas she had previously had 6 to 8 migraine attacks a week. Mitchell and Mitchell found no significant difference between a relaxation group and a no-treatment control group for either frequency or duration of migraine headache.¹⁵

It is usually not possible to correlate sources of tension in a particular patient's life with the onset of headache. Psychogenic factors may be important in many types of headache, but such factors are quite complex.¹⁶ In the present survey, 38% of the patients noted no obvious stress factors which might be contributing to their headaches.

Due to the subjective nature of the questionnaire, treatment failures were difficult to judge. The clinical records proved to be no more enlightening, since a lack of subsequent notes on a patient might mean that cure, treatment elsewhere, or some other outcome. An absolute measure of treatment failure was available, however, in those patients who went on to electro-

myographic (EMG) biofeedback therapy, after gaining no relief from the practice of relaxation skills alone.¹⁷ A group of 4 such patients was found from search of the clinical records. Two patients reported good results, one patient did not complete the course of therapy, and one patient had not yet started EMG biofeedback training.

Although some controversy exists as to the effectiveness of EMG biofeedback when used alone,^{9,18} and in comparison with relaxation skills training,^{10,12} Tsushima and Hawk¹⁷ at Straub Clinic and Hospital have found marked reduction of headache duration and intensity using a combination of EMG biofeedback and relaxation skills training in the treatment of muscle-contraction headache.¹⁷ Studies by Chesney and Shelton, and Wickeramasekera, support the use of a combined muscle relaxation and EMB biofeedback approach as more effective in the treatment of headache than muscle relaxation alone.^{9,8} We have referred our treatment failures to this more involved and time-consuming EMG biofeedback program with satisfactory results.

Summary

A mail survey was made of 80 patients who had been instructed in relaxation skills training. There was a 50% response to the questionnaire. Of 37 patients who suffered from frequent headaches, 34 felt that the exercises were moderately or very successful.

We feel that this technique of progressive muscle relaxation is a useful tool for the treatment of patients with frequent headaches, especially for the patient with muscle-contraction or tension headaches. This simple behavioral approach permits reduction or elimination of pharmacotherapy thereby avoiding the dangers of drug side-effects, drug dependency and drug abuse. Furthermore, it allows the patient to take an active role in his own behalf.

REFERENCES

1. National Research Strategy for Neurological and Communicative Disorders. U.S. Dept. of HEW. NIH publication No. 79-910, June 1, 1979, pp. 83-85.
2. Waters WE: The Pontypridd headache survey *Headache* 14:81-90, 1974.
3. Ziegler DK, Hassanien RS, Coubh JR: Characteristics of life headache histories in a nonclinic population. *Neurology* 27:276-279, 1977.
4. Jacobson E: *Progressive Relaxation* Chicago: University of Chicago Press, 1974, c. 1938.
5. A commercially produced health education program entitled, "Relaxation Skills," available through the Robert J. Brady Co., A Prentice-Hall Company, Bowie, Maryland 20715.
6. Ad Hoc Committee on Classification of Headache: Classification of headache. *JAMA* 179 (9): 127-128, 1962.
7. Fichtler, Helmuth, and Zimmerman RR: Changes in reported pain from tension headaches. *Percept Mot Skills* 36:712, 1973.
8. Wickramasekera I: The application of verbal instructions and EMG feedback training to the management of tension headache—preliminary observations *Headache* 13:74-76, 1973.
9. Chesney MA, Shelton JL: A comparison of muscle relaxation and electromyogram biofeedback treatments for muscle contraction headache *J Behav Ther & Exp Psychiat* 7:221-225, 1976.
10. Haynes SN, Griffin P, Mooney D, and Parise M: Electromyographic feedback and relaxation instructions in the treatment of muscle contraction headache *Behav Ther* 6:672-678, 1975.
11. Tasto DL and Hinkle JE: Muscle relaxation treatment for tension headaches *Behav Res Ther* 11:347-349, 1973.
12. Cox DJ, Freundlich A, Meyer RG: Differential effectiveness of electromyograph feedback, verbal relaxation instructions, and medication placebo with tension headaches. *J Clin Consult Psychol* 43 (6):892-898, 1975.
13. Warner G and Lance JW: Relaxation therapy in migraine and chronic tension headache *Med J Aust* 1:298-301, 1975.
14. Lutker ER: Treatment of migraine headache by conditioned relaxation: a case study. *Behav Ther* 2:592-593, 1971.
15. Mitchell KR and Mitchell DM: Migraine: an exploratory treatment application of programmed behaviour therapy techniques. *J psychosom Res* 15:137-157, 1971.
16. Martin MJ: Psychogenic factors in headache. *Med Clin North Am* 62 (3):559-570, 1978.
17. Tsushima WT and Hawk AB: The clinical application of EMG biofeedback therapy for muscle contraction headaches. *Hawaii Med J* 37 (9) 270-271, 1978.
18. Budzynski TH, Stoyva JM, Adler CS and Mullaney DJ: EMG biofeedback and tension headache: a controlled outcome study *Psychosom Med* 35 (6) 484-496, 1973.



An Expensive Incubus

Once upon a time, the job of the Food and Drug Administration (FDA) was to assure that drugs were safe. It was reasonably assumed that physicians could determine drug efficacy, and that the marketplace would deal with ineffective drugs.

This sensible situation ended in 1962 in the confusion over drug safety during the thalidomide tragedy, when Senator Kefauver and his supporters passed sweeping legislation which granted dramatic new powers to the FDA. The Kefauver-Harris Amendments (KHA) authorized the FDA to require that drugs be *proven effective*, as well as safe, before they could be distributed in interstate commerce. (Ironically, the existing safety requirements had properly kept thalidomide out of the U.S.)

It's relatively simple to prove drug *safety*, but conclusive scientific *proof of efficacy* requires substantial evidence, based on detailed documentation which must be legally as well as medically satisfactory. In order to pass judicial review, withstand legislative inquiry, and protect the regulators, mountains of data are required. New drug applications now average 34 volumes, take years to process, and cost millions of dollars. One recent Lilly application comprised 120,000 pages weighing more than two thousand pounds! Effective, but marginally profitable, drugs simply aren't worth the expense of proving their efficacy.

But the costs are not borne merely by drug purchasers; we all pay for the overblown bureaucracy. The FDA's \$14 million budget of 1960 shot to \$51 million by 1965 while the KHA's were being implemented; it reached \$76 million by 1970, then tripled to \$200 million by 1975. The agency now spends almost \$300 million for this previously unnecessary activity, while the number of drugs in the PDR has actually decreased by 12%.

These details come to light in an outstanding recent review by Dorsey (JAMA 242: 1755), where he considers deregulation of drug efficacy. After painstaking analysis of the risks and benefits from medical, regulatory, and philosophical standpoints, Dorsey concludes that present federal drug laws operate far more to deny patients access to valuable new drugs, than to defend them from truly ineffective ones.

Despite presumably good intentions, the proof-of-efficacy provisions have created an astonishingly expensive federal incubus which increasingly oppresses the pharmaceutical industry, physicians, taxpayers, and especially patients. The Food and Drug Reform Act of 1978, which seeks repeal of the KHA's and limits the FDA's powers to matters of drug safety, deserves our active support. (But beware its look-alike, the Drug Regulation Reform Act of 1978, which intends to *increase* the FDA's powers!)

Considering the defects of regulatory schemes, the wisdom of the *free* marketplace, and the inability of our Republic to continue supporting unproductive activities, it seems clear that this costly and wasteful experiment must end. It's another example in an all-too-familiar parade of good but misguided intentions, gone astray at the hands of government, to the tune of billions of dollars. Enough!

JMC

You Can't Fool Mother Market

Some years ago The Planners decided that they liked a form of medical care delivery very much. They liked it so well that they spent the people's money to establish these systems, which they called HMOs.

But the people didn't seem to like the HMOs very much, and the scheme began to fail. So The Planners took more of the people's money, and gave it to the HMOs to keep them going. They even established more HMOs without ever asking whether the people would patronize them.

Still the people weren't very interested in using these HMOs, so The Planners had to keep taking money from the people to support the system. Since it wasn't their money, The Planners didn't mind spending more of it. At one time there were 200 subsidized HMOs, and the bill was \$155 million.

Finally, some of the people said, "Stop taking our money away and buying things for us that we don't want." Grudgingly, some of The Planners finally obliged. Recently six more subsidized HMOs quietly collapsed, after The Planners had spent \$12 million trying to prop them up.

"Why do you Planners make such dumb plans?" asked the people. "You keep blowing our dough on expensive junk that nobody needs. Let us keep our own money, and decide for ourselves how to spend it. Don't you know you can't fool Mother Market?"

JMC

To Pay or Not to Pay

Whether chiefs of staff of hospitals in our islands should be paid is an increasingly prominent question.

Some hospitals are now paying the chief of staff. Some aren't. Some are considering paying.

In the old days—20 or 30 years ago, the job of chief of staff was simpler. There were fewer problems—legal, governmental, medical.

The explosion of technology has been matched by an explosion of regulations and paperwork, and of vocalization by every group however remotely interested in hospital management.

The explosion of prices should not be overlooked. For a physician in private practice to give up a large portion of "free" time to hospital affairs can eat into the family's resources in a big way.

Is it even fair—or feasible—to expect a doctor to devote many hours to an activity for which the only recompense is glory, public acclaim and personal knowledge of a job well done?

Possibly more physicians could be induced to take on such positions if their time away from earning bread to feed their children could be compensated for in the currency of the day.

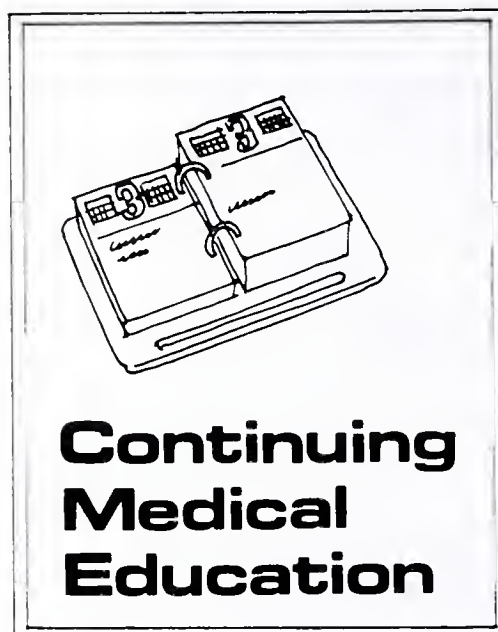
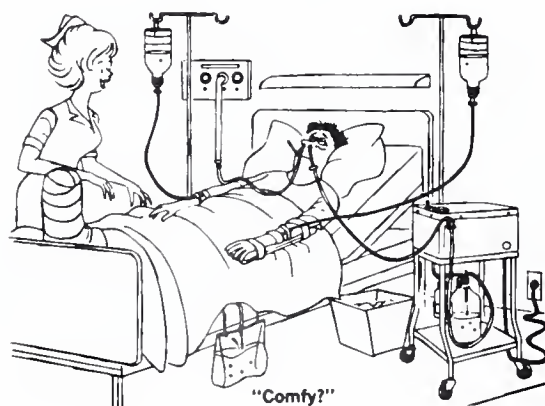
DRJ

"PPD"—Not "PPD-S"!

Dr. Herbert Cohen, Chief of the Tuberculosis Branch of the State Health Department, advises us that the expression "PPD-S" is being used in the Department of Health and probably in the medical community to designate what should be called just "PPD" or "PPD tuberculin", plus the lot number and the producer. It is Tween stabilized, but that doesn't require the "S."

The term "PPD-S" properly designates only PPD from Batch No. 49608, made by Dr. Florence Seibert in 1939 and designated by the WHO in 1952 as the official internationally approved PPD tuberculin. "S" is for Seibert.

HLAJR



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

- B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Grand Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Department of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Fourth Friday, 12:30-1:30 p.m.
6. E.K.G. Conference, June 29, August 31, October 31, 1979, 12:30-1:30 p.m.
7. Visiting Professor's Program
8. Healing Team Mtgs. Fourth Wednesday 12:30-2:00 p.m. (Preventive Med.-Public Hlth. oriented.)

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea mnth. 8:00 a.m. 1 hr. Cat. 1.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 - First—Didactic Presentation
 - Second—Perinatal-Neonatal Topics
 - Third—Obstetrics Topics
 - Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
2. G. I. Conf., Third Tuesday, 8:00-9:00 a.m.
3. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
5. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
7. Surgical Conf., First, Second, & Third Fridays, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 - 1st—Dept. of Medicine
 - 2nd—Dept. of Surgery
 - 3rd—Dept. of OB/GYN
 - 4th—Dept. of Pediatrics
 - 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
 2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
 3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
 4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
 5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
 6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
 7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
 8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. Tumor Conf., Second Monday, 7:30-8:30 a.m. Sullivan 4—Classroom.
- *3. Tumor Mortality & Morbidity Conf., Fourth Monday, 7:30-8:30 a.m., Sullivan 4—Classroom.

4. Renal Conf., First Monday, 1:00 p.m., Sullivan 4—Classroom.
5. EENT Meeting, First Tuesday, 7:00 a.m., Medical Board Room.
- *6. Department of Medicine Mtg., Second Tuesday, 12:30 p.m., Sullivan 4—Classroom.
7. Pulmonary Conf., Second & Fourth Wednesday, 12:30 p.m., Sullivan 4—Classroom.
8. Surgery Grand Rnds. First, Second, & Third Fridays, 7:30 a.m., Sullivan 4—Classroom.
- *9. Surgery M & M Conf., Fourth Friday, 7:30 a.m. Sullivan 4—Classroom.

*For SFH Staff Members Only.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.

8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

June 23, 24, 1980 Laboratory Med., Selected Topics. 2 hrs. ea. day. Held at Kwajalein Missile Range Hospital. Paul Tamura, M.D., speaker.

June 23, 1980 Breast Self-Examination. Sponsored by G.N. Wilcox Hsp., co-sponsor Community Cancer Prog of HI. 12:00 noon - 1 hr. Cat. 1. Held at Wilcox Hsp., Lihue, HI. Contact: (808) 245-4811, Lucy Schwab.

July 26-Aug. 2, 1980 Cardiovascular Med & Surg., An Advanced Course. Stanford U Schl of Med., Stanford, CA 94305. 22 hrs. Cat. 1. Held at Mauna Kea Beach Htl., HI.

July 28-Aug. 1, 1980 Med. Knowledge Self-Assessment Pgrm V. Am. Coll of Phys., 4200 Pine St., Philadelphia, PA 19104. Co-sponsor-J.A. Burns Schl of Med. U of H. 30 hrs. Cat. 1. Held at Kuilima Hyatt Resort Htl., Honolulu. Contact: Dr. Irwin J. Schatz, (808) 546-2810.

Aug. 9-Aug. 16, 1980 Ophthalmology—U of S. CA Schl of Med., 2025 Zonal Ave., L.A., CA 90033. 28 hrs. Cat. 1. Held at Mauna Kea Beach Htl., HI.

Aug. 14, 15, 16, 1980 A Pan-Pacific Conf. on Tuberculosis in the 80s, Am Lung Assoc-spons. HI Thoracic Society. 245 N. Kukui St., Honolulu 96817. Held at the Ala Moana Htl., Honolulu.

Aug. 16-Aug. 22, 1980 Stress & The Physician—Honolulu Med. Grp. Research Ed. Found., 505 So. Beretania St., Honolulu 96813 (808) 537-2211, ext. 751. 22 hrs. Cat. 1. Held at Hyatt Regency Maui Htl., Maui, HI.

Sept. 16, 23, 1980 Gastrointestinal Radiology. San Diego Radiology Res. & Educ Found., Box 2305, LaJolla, CA 92038. Cosponsor-Am Coll of Radiology. Held at Maui Surf Htl. 4 days-30 hrs. Cat. 1.

Oct. 3, 4, 1980 Medicine in the 80's-State of the Art. 7:00-10:00 p.m.-10/3 9:00 a.m.-8:00 p.m. 10/4. Held at Prince Kuhio Htl, Waikiki. Spons. HMA-co-sponsor Unity Church of HI & UH Schl. of Nursing. Contact: John Watson, M.D. (808) 948-8585. 7 hrs. Cat. 1.

Oct. 7-11, 1980 Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. 1. Contact: Mary J.

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Oct. 13-17, 1980

124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8-12noon. Contact: HMA office (808)536-7702 for further info.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



Friday, April 11, 1980
HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Lum, Hindle, Goto, Chinn, Iaconetti, Kam, Don, Hamblin, Chun-Hoon, Lumeng, Morgan, Bruce, Cahill, McNamee, Wigle, Fu, Dang, Saiki, Simmons, Chang, Batten, Hall, Keenan, Mrs. Nancy Simmons and Mrs. Sharon Morton. HMA staff present were: Messrs. Won and Leineweber, Mmes. Wong, Young, Kendro, Chang, and Morioka.

CALL TO ORDER:

The meeting was called to order by President Bell at 5:57 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of March 31, 1980, which indicated that HMA membership totaled 925 in comparison with March 1979 when membership totaled 903.

REPORT OF THE TREASURER:

The January 1980 financial statement was reviewed in detail and approved subject to audit. Also reviewed was the list of members whose dues/capital fund payments were delinquent as of March 31.

Dr. Hindle reported that the Finance Committee met on April 11. The Committee recommended that HMA dues for 1979 be refunded to Dr. Ethel Oda as she was eligible in 1979 for dues-waived status as a Life Member (over 70 years).

ACTION:

It was moved, seconded, and passed to refund 1979 HMA dues to Dr. Ethel Oda.

As follow-up to the last Council meeting, the Committee discussed HCMS's recommendation regarding the scheduling of dues payments in installments. The Finance Committee agreed to investigate the concept of "installment" payments of dues on a semi-annual basis. The Committee will be trying to determine HMA's financial situation if such a system were instituted and will explore other possibilities such as payment of dues with charge cards. Members of the Council felt that the idea of collecting dues on a semi-annual basis might be more favorable if coordination with the AMA can be achieved. A recommendation was made that HMA submit a resolution to the AMA to request that associations be allowed to submit dues on a semi-annual basis.

ACTION:

It was moved, seconded, and passed that HMA submit a resolution to the 1980 AMA House of Delegates to request that associations be allowed to submit dues on a semi-annual basis.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Public Health:

Cancer—Dr. John Keenan reported that the Cancer Committee has been further exploring the concept of developing Hawaii outlines for cancer management, since June 1979 when Council had reservations about approving such a proposal. CCPH Director, Dr. Thomas Hall, summarized for Council what the Cancer Committee had learned from Dr. Edward Moorhead of the Grand Rapids Oncology Program which has developed such outlines and has an ongoing program for disseminating cancer information to physicians. As presented by Dr. Hall, the suggested outlines would be placed in patients' charts temporarily and would serve as an aid or checklist for physicians to consider in caring for cancer patients. The Cancer Committee recommended that Council authorize them to develop a contract with the CCPH to create a set of cancer management outlines for the State of Hawaii. The Council was informed that funding would run for approximately two years.

ACTION:

It was moved, seconded, and passed to authorize the Cancer Committee to develop a contract with the Community Cancer Program of Hawaii (CCPH) to create a set of cancer management outlines for the State of Hawaii.

Substance Abuse/Pharmacy and Sports Medicine—Dr. Cahill reported that the Medicaid Drug Formulary will be discussed in the near future by the Substance Abuse Committee. In the area of Sports Medicine, Dr. Cahill encouraged neighbor island county societies to contact the Sports Medicine Committee if they are interested in holding a seminar on their islands.

B. EMS: Dr. Stanley Saiki presented an update on the EMS program. With regard to the pending SDOH-HMA contract for FY 1979-80, Dr. Saiki reported that the contract will probably be signed within the next few weeks. The budget for Fiscal Year 1980 has been negotiated at approximately \$521,321 with payments being advanced in quarterly increments. The contract will serve as a working model for future

HMA-SDOH contracts for EMS. The DOH is presently looking into the possibility of 2-year contracts with HMA. Council was also brought up to date on the status of pending EMS legislation. Dr. Saiki commended EMS staff, Linda Wright and Jose Lee, who were responsible for writing a federal grant proposal within three weeks for the DOH, following federal guidelines and mandates. The grant is requesting funds to develop an EMS "system" on the counties of Hawaii, Kauai, and Maui. If funded, HMA-EMS will serve as a major subcontractor. The application is presently under review by SHPDA, and it is anticipated that notices of grant awards will be made by DHEW in June 1980.

C. Public Affairs: Dr. Philip McNamee reported that the Public Affairs Committee has received requests from physician members that HMA and the telephone company recognize their sub-specialties in order that they be permitted to be listed in the telephone directory as such. Since it was acknowledged that the telephone company is currently not permitting physicians to create their own specialty listing without authorization from HMA, the Committee recommended that an HMA policy be adopted.

ACTION:

It was moved, seconded, and passed that HMA accepts the American Medical Association's listing of specialty designations. This listing is utilized as a guide for the listing of physicians by specialty in the yellow pages section of many local telephone directories. The listing is utilized by the AMA for its own directories.

However, this listing should not be construed as a guideline for physician specialty advertising. In addition, a telephone directory's utilization of the list should not imply that a physician advertising in the phone book may not use any specialty designation(s) other than those listed.

D. Legislation: Dr. George Goto presented a status report on pending health legislation. It was reported that a special legislative meeting was held on April 1 with specialty society presidents. The societies were encouraged to become more politically active, to support their favorite candidates, and to join HAMPAC. Dr. Bell reported that he recently testified at Congressman Cec Heftel's hearing on national health insurance.

E. Medical Malpractice Insurance Crisis Committee: Dr. Bell reported that the Committee has received to date 171 pledges from physicians and is close to reaching its goal in pledges. Council members were invited to attend the committee's next meeting on April 25.

F. Internal Affairs: Dr. K. Y. Lum reported that the Publication Committee and Public Affairs Committee held a joint meeting to discuss the possibility of a special publication for HMA's 125th anniversary.

G. Peer Review: It was announced that Dr. Ann Catts has just been appointed as Chairman and Commissioner for HMA's Peer Review Committee. The Committee will be studying bylaws relating to peer review of all the county medical societies.

H. Emerging Medical, Moral, and Legal Concerns: Mrs. Bess Chang reported that community representatives and physician members will be meeting in

the near future. The Committee is still in its organizational stage, and it is anticipated that issues such as euthanasia and living wills will be studied.

I. Jail Health Care Project: Dr. Walter Chang reported that the Committee and staff conducted a site visit at the Halawa Correctional Facility. Some of the committee's preliminary observations were noted for Council. It was reported that the State is in the process of changing Halawa to a high security facility. During the next month, site visits are planned for the neighbor island correctional facilities.

J. Computer: Mrs. Becky Kendro reported that HMA's computer will have three general files on all physicians as follows: (1) general information file, (2) physician information file (background such as internship, residency, instructorships, etc., and (3) CME file. To date the general information file has been completed. Eventually the computer information will be sent to physicians for verification, correction and addition of information. With regard to BME's usage of the computer, it was reported that a collection system package has been customized for BME, and it is hoped that the system will be operational by June 1. A recommendation was made that the Executive Committee and Computer Committee develop guidelines for use of the computer.


ACTION:

It was moved, seconded, and passed that the Executive Committee and Computer Committee develop guidelines for use of the computer.

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F. Health Service and Care: Mrs. Becky Kendro reported that the Health Care Costs Committee has met with representatives of hospitals and third party carriers. Areas being studied are pre-admission screening, outpatient surgery, and the possibility of a pilot project. The Health Manpower Committee is slated to meet with representatives of the nursing profession who are involved in revision of the nurse practice act.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Calvin Kam reported that the HCMS will hold its next general membership meeting on May 13 at the Pacific Beach Hotel. Attorney Elliot Loden will be the featured speaker and his talk will focus on tax shelters and estate planning. The Society has tentative plans to hold a legislative wrap-up session in June.

B. Maui. Dr. Andrew Don reported that Maui county recently participated in the Wellness Celebration. In March the Society met with Pacific PSRO President, Dr. Winfred Lee. The Society is currently looking into the possibility of improving the quality of their exchange by utilizing the services of the Physicians Exchange of Honolulu. Plans are being made to invite Maui's Mayor to their next meeting and to hold a social event with Maui legislators.

C. Kauai: President Bell welcomed Dr. Robert Hamblin, Kauai County President, to his first Council meeting. Dr. Bell and Mr. Won are slated to attend the Society's next quarterly meeting.

OTHER BUSINESS:

A. Auxiliary: With Ho'olaulea right around the corner, Mrs. Nancy Simmons and Mrs. Sharon Morton encouraged Council members to attend the Auxiliary's fund raiser for the Hawaii Medical Library on April 19.

B. Liaison Administrative Staff Program: Announced by Mr. Jon Won was the establishment of a primary contact, liaison administrative staff program. Designed mainly to assist all counties in obtaining desired information, each society has been assigned a primary contact person as follows:

Hawaii	- Becky Kendro
Honolulu	- Irene Wong
Kauai	- Bess Chang
Maui	- Ceci Young

C. Informed Consent: Members of the Council commended Dr. Bell on his recent memorandum to the membership regarding informed consent rules. A suggestion was made that efforts should be made to keep members abreast on matters such as Informed Consent, Workers Compensation, No-fault, and other key health laws or regulations that have or will come into effect. It was felt that such information could also be included in membership packets to assist new members.

ADJOURNMENT:

The meeting was adjourned at 9:00 p.m.



James P. McGuire, M.D.

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Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

We have no **new members** to report this month.

However, travel is the order of the day in **news of members**. **Jim Tsuji** will attend the State Officers Conference in Kansas City in early May; at about the same time, **Don** and **Marlies Farrell** will be in Boston for the annual meeting of the Society of Teachers of Family Medicine after which they will leave for a visit to Germany. Also taking in the sights of Europe during May will be HAFP president **Pat Dietrich** with spouse

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Dewey, while **Nate Wong** left in late April for Tahiti to join the crew of the *Hokule'a* on its return voyage. Just returned from a trip to Panope, Micronesia, are **Lily Ning** and hubby **Jerry Prentice**. Jerry was on a UH sponsored teaching assignment in anesthesiology. In the same location could be found **Ben Diniega**, 3rd year FP resident at Kaiser, doing a preceptorship. His return flight must have passed **Al Chun's** plane on his way to replace him. The Academy is on the move!

Our April 26th **Dinner Meeting** was graciously hosted by the **Garton Walls** at their lovely Tantalus Drive home. 48 members, students and guests were "updated" on rheumatology by **Dr. Singleton**, who came all the way from California (another traveler). An interesting film on the joint AAFP and WONCA meeting in New Orleans next October made everyone anxious to sign up early for a tour of Bourbon St. as well as the usual educational offerings.

During its April meeting the Exec Council heard a report from **Tom Cahill** on important matters considered by the **Legislative Committee** and **Board of Governors** of the HMA, where he represents our Chapter.

- 1) The DDS has just issued a formulary for mandatory use on DSS assisted patients, starting May 1. HMA opposes.
- 2) HMA backs Medicaid fee increase, 1975 fee schedule is still in use. Fee increase is not expected.
- 3) New State law on informed consent is now in effect. Model consent forms (well written) are available thru Dept. of Regulatory Agencies.
- 4) Dead this session is legislation to authorize State publication of an RVS scale.
- 5) Also dead this session, but sure to be resurrected next year, is the proposed Hawaii Health Agency bill. This would create a new super-bureaucracy with sweeping powers to oversee the distribution and cost of health care.
- 6) The Board of Governors decided, that HMA committees will no longer review fee or malpractice complaints against non-member physicians. Another good reason for all MD's to join HMA-AMA, urges Tom.

Watch your mail for information about the **June Dinner Meeting** to be hosted by Varian and Erna Sloan.

Our "Angels"

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From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

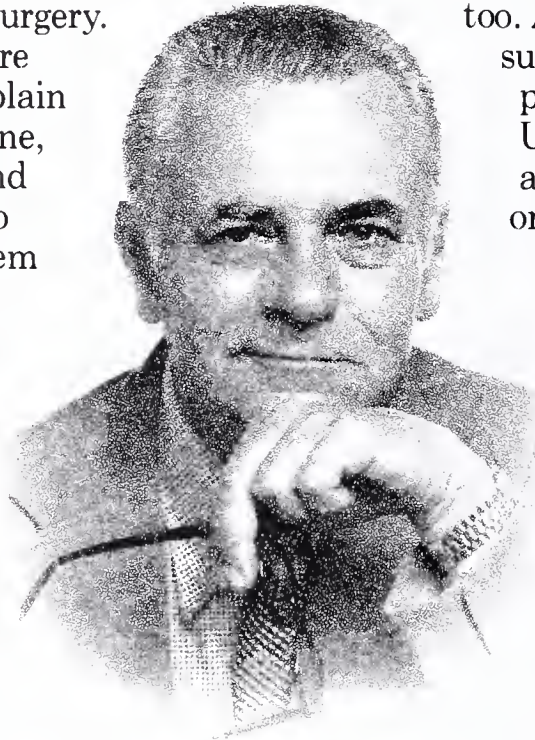
To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

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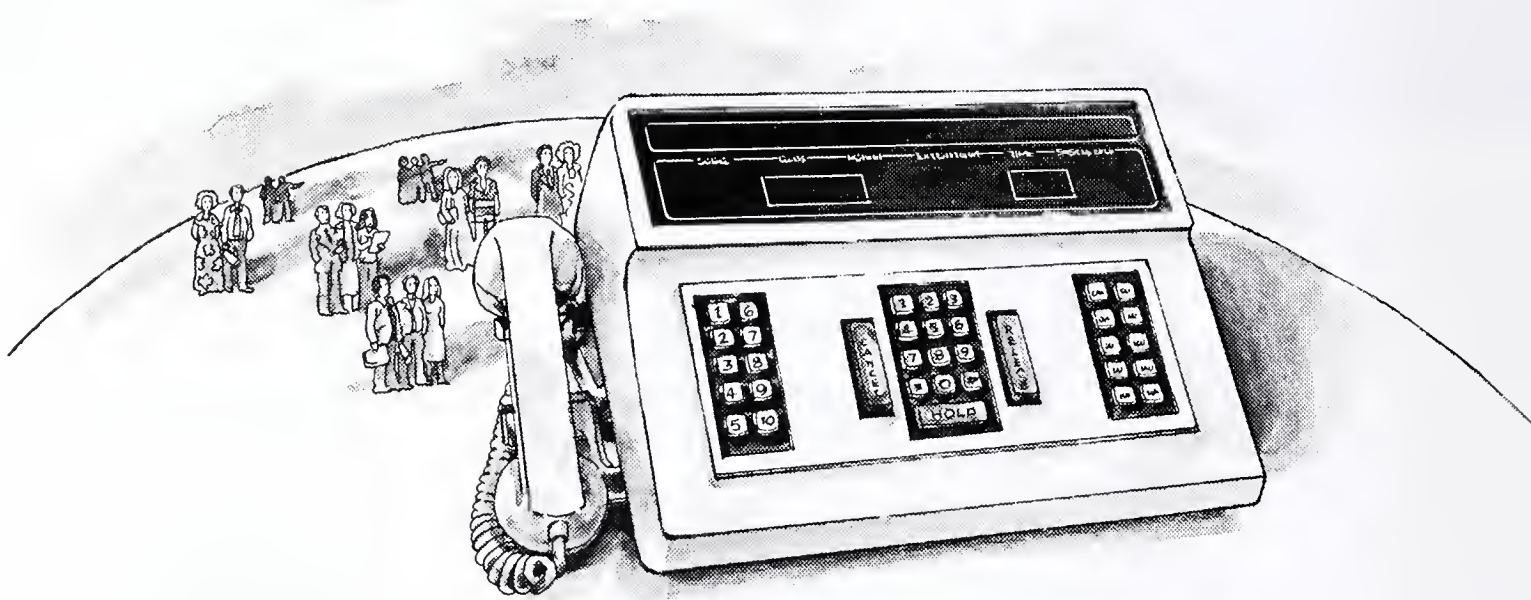
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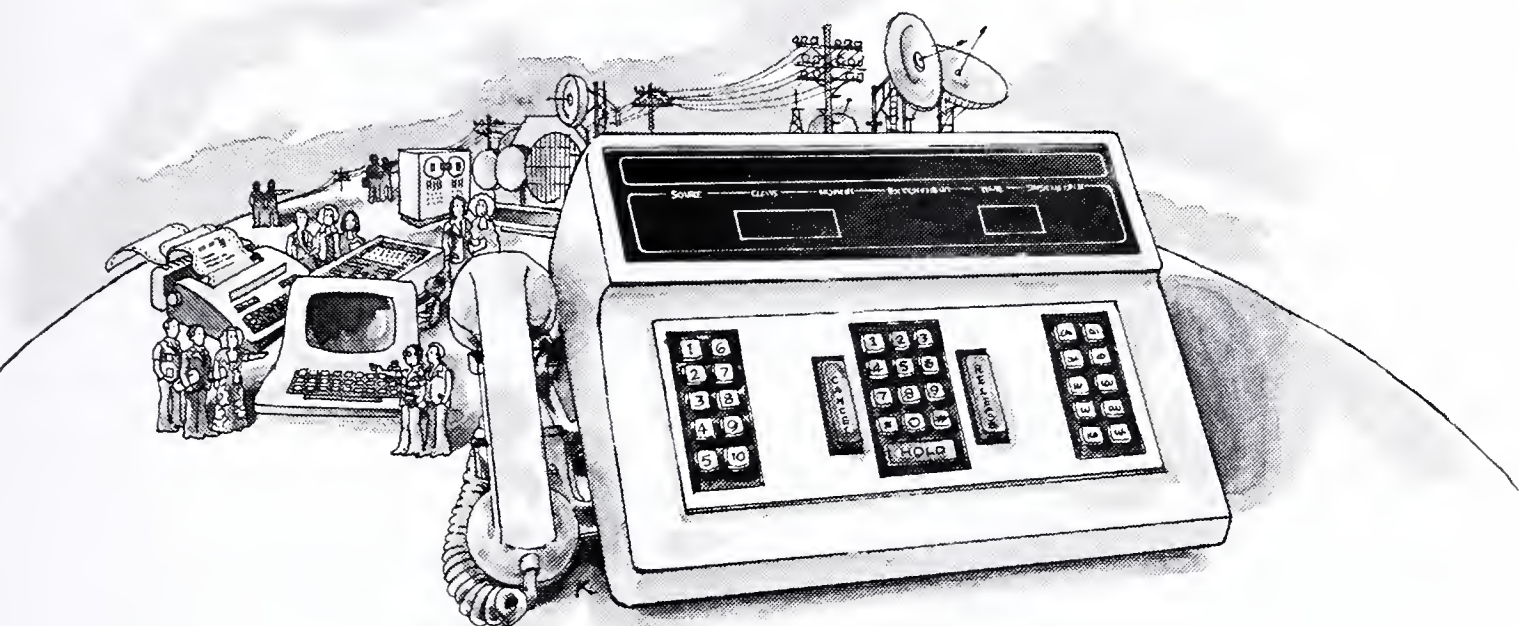


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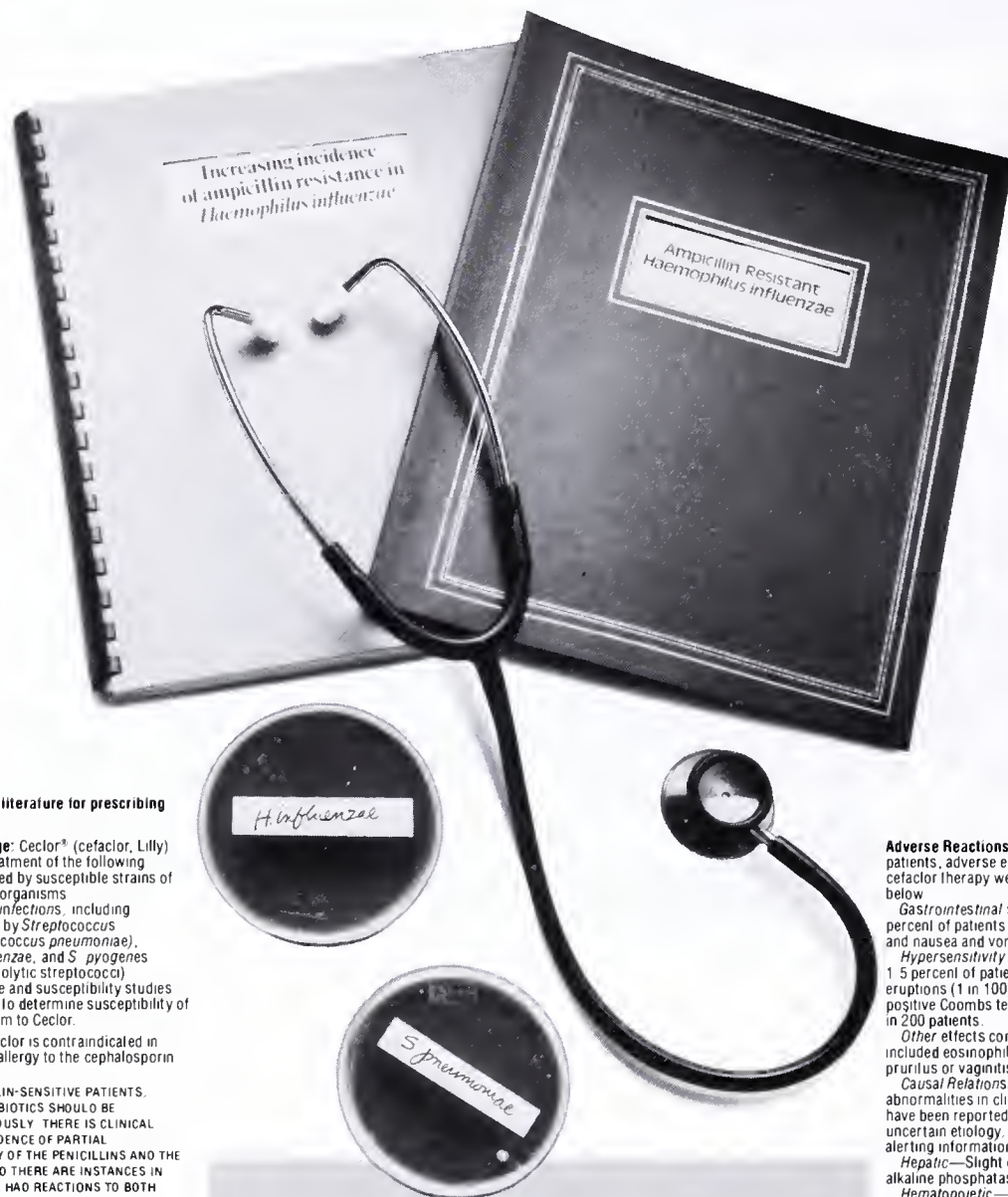
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Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

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Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother. 8:91, 1975.
2. Antimicrob. Agents Chemother. 11:470, 1977.
3. Antimicrob. Agents Chemother. 13:584, 1978.
4. Antimicrob. Agents Chemother. 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother. 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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Symptomatic Screening for Inborn Errors of Metabolism

THOMAS H. THELEN, Ph.D., HERBERT S. UEMURA, M.D. and
Y. EDWARD HSIA, BM, MRCP, DCH, *Honolulu*

● *Rare inherited metabolic disorders can present with non-specific biochemical disturbances or neurological symptoms. A series of simple chemical screening tests will detect abnormal urine composition in many of these disorders and can help single out patients for further evaluation of specific inherited metabolic disorders.*

We describe local experience with a battery of simple tests in the first 50 patients tested. Among the 20 abnormal results, 11 were due to drug artifact; one to hepatocellular disease; one to heterozygous cystinuria; one to hyperoxaluria; one to benign glycinnuria; and three were from known phenylketonuria patients. One patient had mucopolysaccharidosis and one patient with hyperammonemia was found to have argininosuccinic aciduria.

These tests, combined with experienced clinical judgment, have utility for ruling in or ruling out many rare inherited metabolic disorders.

Most inborn errors of metabolism are individually very rare, yet collectively they cause a sizable amount of human disease. Recognition of these can be of critical importance for effective preventive treatment of these disorders.¹ Correct diagnosis can also provide vital information about possible threats to living or future relatives.²

Although presymptomatic screening, eg, of newborns for phenylketonuria, has been of proven benefit in many populations, some patients may be missed, and many rarer diseases are not detectable by standard newborn metabolic screening tests.¹⁻³ Many metabolic errors cause acidosis, lactic acidosis, ketosis, hyperam-

monemia, or disturbances secondary to hepatic or renal damage.⁴ Many of these disorders produce growth failure, neurological abnormalities with or without retardation, seizures or occasionally disturbances of movement.⁵ While the majority of inherited metabolic diseases present in infancy or childhood, others, such as Wilson's disease, cystinuria and porphyria, are diseases of adulthood. Recognition of these is often difficult, but some simple steps can help to sort out those patients who should have more definitive tests.⁶

Clinically, a physician should be alert to genetically associated disorders in patients with suggestive symptoms or signs. The family history should be checked for similarly affected relatives, unexplained brain damage, or infant deaths from unknown causes. A battery of simple chemical urine tests can help to sieve out patients with possible inborn errors of metabolism.⁷

We review here the application locally of such a battery of tests, and report on our preliminary experience with the first 50 patients screened.

Methods

Urine specimens were accepted from physicians for detection of suspected inborn errors of metabolism. In addition, urine was obtained from 2 patients known to have phenylketonuria while they were on an unrestricted diet; and from one patient with cystinosis.

Five to 25 ml of urine, preferably an early morning specimen, was collected in a clean container and frozen (to inhibit microbial proliferation) until tested.

On thawing, each specimen was inspected for color, odor (Table 1), concentration and precipitates. A simple commercial test was used for protein, glucose, ketones and blood. ("Multistix" Ames®).

From the Departments of Genetics, & Pediatrics, John A. Burns School of Medicine and Department of Pathology, Kapiolani-Children's Medical Center. Address Reprints to Y.E. Hsia, 1310 Punahou Street, Honolulu, HI 96826. THT was supported by PHS Grant No. HD 00400-05 Training Program in Human Genetics. Accepted for publication January, 1980.

TABLE 1.—*Urine Odors and Appearance in Some Inborn Errors of Metabolism*

COLOR*	POSSIBLE DIAGNOSIS
Port wine	Acute Intermittent Porphyrria Congenital Erythropioetic Porphyrria
Black (on standing)	Alcaptonuria
SMELL*	
Sweet, aromatic	Any cause of ketosis
Maple syrup	Maple syrup urine disease
Musty, mousy	Phenylketonuria (untreated)
Rancid butter	Hereditary tyrosinemia
Sweaty feet	Isovalericacidemia
Cat's urine	β -Methylcrotonylglycinuria
Stale fish	Trimethylaminuria
Dried celery	Oasthouse urine disease
DEPOSITS*	
Sandy urate deposits	Lesch-Nyhan disease
Needle-like crystals	Orotic acidurias, some hyperammonemias
Blue staining of diapers	Tryptophan malabsorption
Flat hexagonal crystals	Cystinuria
Ditetragonal pyramid crystals	Oxalosis

*Many drugs, food additives, or contamination after excretion can produce unusual colors, smells, and deposits.

Spot Tests

a) Reducing substances:

The copper sulphate reducing test ("Clinitest" Ames®) will react with any reducing substance such as glucose. Whenever a specimen is "Clinitest" positive, it is rechecked with the glucose-specific "Clinistix" (Ames®) Table 2 lists several non-glucose reducing substances and their possible causes.⁷⁻⁹

TABLE 2.—*Urine Reducing Substances*

SUBSTANCE*	POSSIBLE CAUSES
Glucose	Diabetes mellitus Low renal threshold Familial glycosuria Glucose-Galactose malabsorption Renal tubular damage such as from Cystinosis, Wilson's disease, etc.
Lactose	Lactose intolerance
Galactose	Galactosemia (untreated) Glucose-Galactose malabsorption
Fructose	Benign fructosuria Fructose intolerance
Pentoses	Benign pentosuria

*Dietary excesses, chemicals and drugs such as ascorbic acid, chloral hydrate, Rengrafin® or large doses of some antibiotics will give a false positive reaction.

b) The ferric chloride test:

A saturated solution of ferric chloride is added to a small amount of urine until the urine is completely cloudy. Any unusual color which develops immediately or after standing for 20-30 minutes is noted. This reagent reacts with phenols, enols, β -keto esters and α -keto acids. Ketone bodies produce a rich port-wine color which is absent from a boiled urine sample. The phenylketones of phenylketonuria develop a

bluish-green color that fades in 20 minutes. Salicylates produce a brown color that persists in boiled urine. Many other color changes are listed in Table 3.⁷⁻⁹

TABLE 3.—*The Urine Ferric Chloride Test*

COLOR REACTION	POSSIBLE CAUSES
Dark green or Transient green	Phenylketonuria Tyrosinemia Cirrhosis and Jaundice Pheochromocytoma Carcinoid L-dopa medication Iodochlorhydroxyquin
Blue, transient	Alcaptonuria
Purple	Diabetic ketoacidosis Other ketoacidosis such as starvation Maple syrup urine disease Histidinemia Salicylates Phenylthiazine derivatives
Red	Antipyrine
Yellow-green	Isoniazid

c) The dinitrophenylhydrazine (DNPH) test:

Upon adding an acidic solution of DNPH to some urine, a yellowish-white turbidity or precipitate forms when there is excess α -keto acids or ketone bodies present. Positive specimens are checked with "Acetest" (Ames®) tablets which will react primarily with acetoacetate and acetone. Table 4 lists some possible causes for a positive DNPH test.⁷⁻⁹

TABLE 4.—*The Urine Dinitrophenylhydrazide Test for Ketoacids*
POSSIBLE CAUSES OF POSITIVE RESULTS*

Diabetic ketoacidosis Other causes of ketoacidosis, such as starvation propionic acidemia Methylmalonic acidemia Maple syrup urine disease Isovaleric acidemia Glycogenosis type I Fructose 1-6, diphosphatase deficiency The Lacticacidoses

*False positive results can arise from: drug metabolites, X-ray contrast material, and urine contamination.

d) The nitroprusside test:

Adding a sodium cyanide solution to alkalized urine will reduce disulfide bonds to free sulphydryl groups; then a sodium nitroprusside solution will yield a transient deep cherry color with the sulphydryl groups, indicating excess of a sulfur amino acid or a derivative. (Table 5)⁷⁻⁹

TABLE 5.—*The Urine Nitroprusside Test for Sulphydryl Groups*
POSSIBLE CAUSES

Cystinuria Homocystinemia Severe general aminoacidurias Drug artifacts

e) The acid albumin test:

A fresh solution of 10% bovine albumin in

acetate buffer will cause urine to develop turbidity or a precipitate in the presence of small soluble proteins. A positive test is often found in most of the mucopolysaccharidoses. Table 6 lists possible causes of true and false positive tests.

TABLE 6—The Acid Albumin Test for Mucopolysaccharides

POSSIBLE CAUSES
Hurler syndrome
Hunter syndrome
San Filippo syndrome
Scheie syndrome
Other causes of proteinuria
Heparin therapy

Amino Acid Chromatography

The final part of the screening process is two-dimensional thin-layer chromatography. In the procedure used, a few microliters of urine is spotted near the lower left-hand corner of a 20 x 20 cm silica gel G coated glass plate. The urine is dried and the plate is placed in a closed glass tank containing the solvent mixture chloroform, methanol, concentrated ammonium hydroxide (58%) and water (10:10:6:3, vol/vol). As this solvent system migrates up the plate, metabolites in the urine are carried with the solvent up the plate, each metabolite having its own characteristic rate of migration in the solvent system. After sufficient migration has occurred, the glass plate is removed from the tank and dried. It is then rotated 90° counter-clockwise for the second dimension and placed in another closed tank containing butanol, glacial acetic acid, and water (3:1:1, vol/vol). This second system helps to separate substances which have similar migration rates in the first system. After sufficient migration has again occurred, the plate is removed from the tank and dried. It is then sprayed with a fresh ninhydrin-isatin solution and heated to enhance the color reaction of the ninhydrin and isatin with α-amino compounds, revealing a pattern of spots and streaks.¹⁰ The positions and relative densities of the spots indicate amino acids present in the urine specimen. If an abnormal pattern is found, individual spots can be identified by comparison with the migration of known amino acid markers. When an abnormal spot co-chromatographs with a known amino acid, it is presumed to be the same amino acid. Quantitative amino acid chromatography is used to confirm these findings.⁷⁻¹⁰

Confirmatory quantitative amino acid analyses on plasma and urine samples from patients with unusual amino acid patterns were run on an automated (120-C Beckman, Fullerton, California) amino acid analyser, or were sent to Dr. C.R. Scott (U. of Washington, Seattle) for additional tests and interpretative advice (Table 7).

Results

Table 8 summarizes the findings in the first

TABLE 7—Abnormal Urine Amino Acid Patterns as Detected by Two-Dimensional Thin-Layer Chromatography

POSSIBLE CAUSES	
<i>Pre-Renal</i>	
GENERALIZED AMINO ACIDURIA*	Hepatocellular damage (includes fructose intolerance, citrullinemia, tyrosinosis, etc.)
<i>Renal</i>	
	Tubular immaturity
	Tubular damage (includes galactosemia, cystinosis, Wilson's disease, etc.)
SPECIFIC AMINO ACID ELEVATIONS*	
Aromatic	Prematurity
	Phenylketonuria
	Tyrosinemias
Branched chain	Maple syrup urine disease
	Isovaleric acidemia
Neutral	Hyperglycinemias
	Hyperglycinurias
	Some Lactic acidoses
Basic	Hyperammonemias
	Hyperlysinemias
	Lysinuric protein intolerance
	Argininemia
Basic and Cystine	Cystinuria
Also: Homocystinuria, Histidinemia, etc.	

*Can be caused also by dietary imbalances or mimicked by drug derivatives.

50 patients. (None of these had diabetes or proteinuria).

Spot test results on the first 50 patients were informative in 6 patients. Typical positive ferric chloride tests were found for the 3 phenylketonuria patients. A 3-week-old infant, diagnosed by blood tests as having phenylketonuria, was not yet excreting enough phenylketones to

TABLE 8—Results of First 50 Patients Screened

ABNORMAL RESULTS	
SPOT TESTS:	
Normal	45
Reducing Substances	1
Ferric Chloride	3 (Green)
Dinitrophenylhydrazine	0
Nitroprusside	1
Acid Albumin	1
TOTAL:	50*
AMINO ACIDS:	
Normal	32
DRUG ARTIFACTS:	
Antibiotics	8
Anticonvulsants	3
Generalized Aminoaciduria	3
Aromatic	3 (Phenylalanine)
Branched-Chain	0
Neutral	1 (Glycine)
Basic	1 (Argininosuccinate)
Basic and Cystine	1 (Slight)
TOTAL:	50*

*Some patients had more than one abnormality.

produce an abnormal ferric chloride test. One other patient with severe hepatitis had a ferric chloride test which became green after a delay of several minutes. This patient's urine was quite dark and foamed readily on shaking. The nitroprusside test was faintly positive once and negative once in a patient who had hyperglycinuria (see below). Of 2 patients with mucopolysaccharidoses, one had a positive acid albumin test, the other had a negative result which was positive on retesting elsewhere.

Two-dimensional thin-layer chromatography was more informative, but required cautious experienced interpretation.⁹ For 8 patients, in the region normally occupied by phenylalanine, a yellow spot appeared which turned purple after 15 minutes, becoming indistinguishable from the purple amino acid spot. All 8 of these patients had been on antibiotic therapy with a penicillin derivative. This spot disappeared on retesting 2 patients after they had discontinued antibiotics. The spot, therefore, was a drug artifact. In 3 patients taking anticonvulsants for seizure disorders, an extra violet spot appeared in the leucine region, disappearing on retesting one patient after anticonvulsants were discontinued; hence it was also a drug artifact.

One young adult had a prominent spot in the lysine region. Dr. C.R. Scott confirmed that this patient's urine had increased lysine and slightly increased cystine, although the nitroprusside spot was negative. This pattern is consistent with the benign heterozygous state for type II or type III cystinuria, in which a partial renal transport defect for cystine and dibasic amino acids is found, (This patient's parents were unavailable for testing; his sister's urine was normal; and no relative was known to have had renal stones).

A sample from a 7-week-old patient, with sudden coma from hyperammonemia, had an intense ninhydrin-positive reaction which totally overwhelmed the lysine-arginine region. There was also a barbiturate-derived spot. Upon four-fold dilution and co-chromatography with arginine, 3 spots were resolved which were consistent with the positions of argininosuccinate and its anhydrides. The patient was confirmed to have argininosuccinic aciduria by tissue and enzyme analyses.¹¹

A 7-year-old patient with an obscure acute encephalopathy had elevated urine glycine, confirmed by quantitative analyses on several specimens. She was the patient with a faintly positive nitroprusside test in one of these specimens. (Further testing by Dr. C.R. Scott revealed a modest degree of glycinuria with no increase in plasma glycine.) These findings were judged to be of no clinical significance and irrelevant to her problems.

General increase of urine amino acids is difficult to assess, because amino acid levels in the urine show so much variability. All amino acids

are normally higher in the urine of newborn infants until renal tubular reabsorption has matured; many drugs and heavy metals have transient toxic effects on the tubules, resulting in generalized aminoaciduria; and any severe hepatocellular disease can produce heavy aminoacidemia with overflow into the urine. One infant who had many birefringent oxalate crystals in the urine had moderate increase of all amino acids. An adult female with a familial degenerative ataxia-spasticity syndrome had generalized aminoaciduria of as yet undetermined cause. Four other specimens with possibly increased aminoaciduria were checked by Dr. C.R. Scott and interpreted as normal.

Discussion

Many patients may manifest symptoms and signs suggestive of one or another rare inborn error of metabolism. The majority of these patients will prove to have a non-genetic basis for their disorder. The challenge of finding the occasional patient who merits full investigation requires a sensible screening process backed up by adequate resources for further testing.

Routine urine analyses and chemical tests on blood may suggest an inherited biochemical disturbance. Since many of these disturbances are subtle or technically difficult to detect in the blood, most abnormal metabolite excesses are more easily detected in the urine, which represents the overflow from body metabolism.

The battery of urine tests described here has been developed from extensive experience in many centers.^{1,2,7-9} The thin-layer chromatography separates individual amino acids, but the pattern or its density can vary for many reasons. Fortunately, the known aminoacidopathies are generally associated with huge increases of one or more amino acids well beyond the normal range. All these tests have utility if used critically, but can mislead if the possibilities of false negative and false positive results are overlooked.

False negative results can be due to inappropriate use of a test, clerical or technical error, lack of sensitivity of the test, lack of specificity of the test, and patient variability.

A false negative test occurred in one of 2 patients with a mucopolysaccharidosis (confirmed elsewhere), who had a negative acid albumin test. Although it is the most useful of the simple qualitative tests for urine mucopolysaccharides,⁷⁻⁹ the test is inconsistently positive even in known patients, because it is sensitive to urine ionic concentrations.

False positives can be even more misleading if wrongly interpreted. They can arise for the same reasons that cause false negative tests. In addition, diet excesses, as well as drugs and chemicals, can cause abnormal spot tests or distort the urinary amino acid pattern. Also, non-hereditary pathological conditions or metabolic changes can

produce positive spot tests or abnormal urine amino acids.

Some screening test results are so characteristic for certain disorders that the diagnosis is immediately evident. An example was the patient with hyperammonemia due to argininosuccinic aciduria. In the child with hepatitis, who had abnormal spot tests and elevated amino acids, the abnormal results arose from severe liver damage, so the tests contributed no information about a primary cause for her liver disease. An abnormal screening test result therefore, merely suggests that a metabolic disease may be present. Additional tests and consultations may be needed before a definitive diagnosis can be made.

Interpretation of amino acid patterns can be facilitated by comparison with spot test results, and by considering information about the patient's age, clinical status, and medications. For this reason, the use of commercial facilities for amino acid chromatography alone is misleading or worthless. A commercial report, eg, of slight elevation in branched-chain amino acids, requires cautious scepticism lest it leads to erroneous conclusions or misguided investigations. Costly quantitative amino acid analyses are also rarely indicated, unless preliminary screening results demonstrate an abnormality worth investigating. In the same way that most physicians expect specialist interpretations for X-ray, EEG, bone marrow and histology reports, metabolic screening reports should consist of more than raw test results.

The objective of screening tests is to cull out the patients with a probable diagnosis from a larger group of patients with a possible diagnosis. These tests should be simple, economical, with a low false negative rate and with a false positive

rate for which suitable confirmatory tests are available. The battery of screening tests outlined here meets most of these criteria.

There are serious limitations however, to these tests. They will miss metabolic disorders such as some of the hyperammonemias, many disorders of organic acid metabolism, and all the sphingolipidoses. Hence they do not screen for all genetic diseases or even all inherited metabolic diseases. Eventually, newer improved tests will replace the currently used ones, but at present this battery represents a practical compromise.

Once a metabolic disease has been diagnosed, considerations about prognosis, treatment, and psychological support must follow.^{1,2} Many metabolic diseases are treatable,¹ particularly when the disease is detected early. In others, the prognosis is poor, but in all of these, correct diagnosis and appropriate psychological support for the parents are needed.

Genetic counseling must also be considered when an inherited metabolic disease has been diagnosed. Even though the incidence of individual inborn errors is very low, the recurrence risk for siblings or other relatives of an affected patient is as high as 25 or 50%. Parents and other relatives frequently want and need to know these risks. They should also be informed whenever prenatal testing can be offered.²

Our experience with the first 50 tests confirms that these tests can help rule in or rule out important genetic diagnoses in the Hawaiian patient population, when the patients are selected by broad criteria, and the test results are interpreted cautiously in the context of relevant clinical data.

REFERENCES

1. Milunsky A (ed): The Prevention of Genetic Disease and Mental Retardation. Saunders, Philadelphia, 1975.
2. Hsia YE, Hirschhorn K, Silverberg RL, et al (ed): Counseling in Genetics. AR Liss, New York, 1979.
3. Committee on Genetics: Screening for congenital metabolic disorders in the newborn infant: congenital deficiency of thyroid hormone and hyperphenylalaninemia. *Pediatrics* 60:389-404, 1977.
4. Hsia YE, Wolf B: Inherited metabolic disorders. In: Avery GB (ed): Neonatology (ed 2). Lipincott, Philadelphia, in press.
5. Hsia YE, Wolf B: Disorders of amino acid metabolism. In: Siegel GJ, Albers RW, Katzman R, Agranoff BW (eds): Basic Neurochemistry (ed 3). Little Brown, Boston, in press.
6. Holtzman NA: Rare diseases: common problems. *Pediatrics* 62:1056-1060, 1978.
7. Thomas GH, Howell RR: Selected Screening Tests for Genetic Metabolic Diseases. Yearbook, Chicago, 1973.
8. Schmidt L: The biochemical detection of metabolic disease: screening tests and a systematic approach to screening. In: Nyhan WL (ed) Heritable Disorders of Amino Acid Metabolism. Wiley, New York, pp 675-697, 1974.
9. Hill A, Casey R, Zaleski WA: Difficulties and pitfalls in the interpretation of screening tests for the detection of inborn errors of metabolism. *Chim Chim Acta* 72:1-15, 1976.
10. Saifer A: Rapid screening methods for the detection of inherited and acquired aminoacidopathies. *Adv Clin Chem* 14:145-218, 1971.
11. Perry TL, Wirtz MLK, Kennaway NG, Hsia YE, Atienza FC, Uemura HS: Amino acid and enzyme studies of brain in an infant with argininosuccinic aciduria. *Chim Chim Acta*, in press.



Who's In Charge?

The Hawaii State Health Planning and Development Agency (SHPDA) Physician Manpower Study of 1979 revealed that about 1450 practicing physicians served 888,000 patients, for a ratio of 163 clinicians per 100,000 population. This figure, currently in the mid-range of professional recommendations for doctor-patient ratios, increases annually as physicians multiply faster than patients. The Study found an appropriate physician "mix," with ratios within or above recommended ranges in most medical specialties.

To maintain current physician-patient ratios, even in the face of projected population increases, requires an infusion of fewer than 50 physicians per year.

A surprising 267 Hawaii medical licenses were issued in 1979, most of these by endorsement from other states. If only half of these licensees were to enter clinical practice, the number of physicians would increase by 9%, while the population grows about 1.4%.

Meanwhile, the University of Hawaii School of Medicine just graduated 72 physicians, two-thirds of whom indicate a preference for practice in Hawaii. So far, only one-third of the initial class of 1975 has finished graduate training and entered practice in Hawaii.

As a result of these trends, medical manpower increases. The SHPDA Study projects about 190 physicians per 100,000 within 2-3 years, and up to 210 per 100,000 by 1985. This increase of almost 30% in the ratio of physicians to population in five years, portends a profound impact on the manner of medical practice in 1985.

Watching our 72 new physicians, most of whom won't complete graduate training for 4-5 years, one wonders about the opportunities for practice on their return. There seems no quarrel with the concept of training physicians from Hawaii for Hawaii. But for the University to keep

popping out graduates in the face of increasing mainland arrivals, while physician manpower projections soar off the scale, seems a bit unsettling. Many physicians complain that business seems a little slow already, while the nurses are clamoring to open up shop. Who's in charge here, anyway?

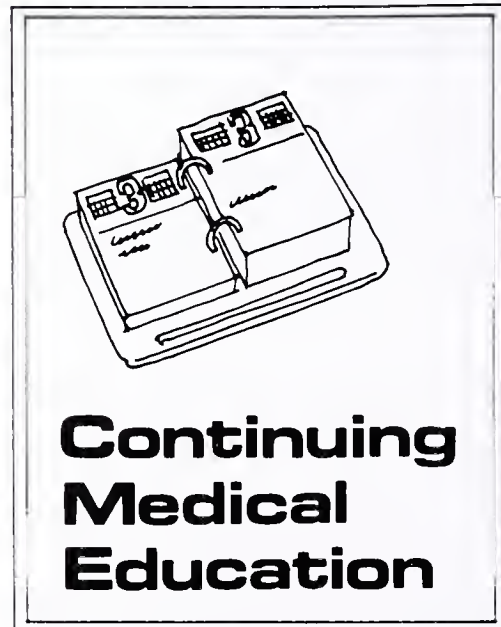
JMC

Good News!

Item: After four years, the Hawaii Medicaid Program finds all requests for C.A.T. Scan to be medically necessary. Fancy that! Perhaps more surprising, prior authorization will no longer be required. It took only four years of reviewing every request, for the State to determine that physicians seem to know what they're doing. (But who decides whether the State knows what *it* is doing?)

Item: The H.E.W. recently completed a \$300,000 study which concludes that less than 1% of the nation's surgery is unnecessary. House Commerce & Health Sub-committee hearings in 1976 had contended that 17% of surgery was "not necessary." Although this report was clearly refuted by several medical studies, the Subcommittee clung to the previous figure; perhaps they'll now accept this expensive proof. Since 99% of surgery proves appropriate, it shouldn't take another costly study to show that mandatory second-opinions aren't cost-effective. (That \$300,000 could have paid for a lot of *necessary* surgery.)

JMC



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hos-

pital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.

9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea mnth. 8:00 a.m. 1 hr. Cat. I.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Ophthalmology Departmental Mtg., First Tuesday, 1:00-2:00 p.m.
2. G. I. Conf., Third Tuesday, 8:00-9:00 a.m.
3. Depart. of Medicine Mtg., (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conf., Fourth Wednesday, 8:00-9:00 a.m.
5. Oncology Conf., Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conf., Third Thursday, 1:00-2:00 p.m.
7. Surgical Conf., Second & Third Fridays, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
9. Endocrine & Metabolism Conference, First, Second, Third, and Fifth Wednesday, 7:30-8:00 a.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. Tumor Conf., Second Monday, 7:30-8:30 a.m. Sullivan 4—Classroom.
- *3. Tumor Mortality & Morbidity Conf., Fourth Monday, 7:30-8:30 a.m., Sullivan 4—Classroom.
4. Renal Conf., First Monday, 1:00 p.m., Sullivan 4—Classroom.
5. EENT Meeting, First Tuesday, 7:00 a.m., Medical Board Room.
- *6. Department of Medicine Mtg., Second Tuesday, 12:30 p.m., Sullivan 4—Classroom.
7. Pulmonary Conf., Second & Fourth Wednesday, 12:30 p.m., Sullivan 4—Classroom.
8. Surgery Grand Rnds. First, Second, & Third Fridays, 7:30 a.m., Sullivan 4—Classroom.
- *9. Surgery M & M Conf., Fourth Friday, 7:30 a.m. Sullivan 4—Classroom.

*For SFH Staff Members Only.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.

9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

- | | |
|---------------------------|--|
| July 16-19, 1980 | Fifth Annual Summer Seminars in Pathology. Sponsor-J. A. Burns Schl of Med. Held at Wailea Beach Htl, Maui. |
| July 21, 26, 1980 | Social Work Practice with Sex Related Problems. U of H College of Social Work. Held at Ala Moana Htl, Honolulu. |
| July 26-Aug. 2, 1980 | Cardiovascular Med & Surg., An Advanced Course. Stanford U Schl of Med., Stanford, CA 94305. 22 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI. |
| July 28-Aug. 1, 1980 | Med. Knowledge Self-Assessment Pgrm V. Am. Coll of Phys., 4200 Pine St., Philadelphia, PA 19104. Co-sponsor-J.A. Burns Schl of Med. U of H. 30 hrs. Cat. I. Held at Kuilima Hyatt Resort Htl., Honolulu. Contact: Dr. Irwin J. Schatz, (808) 546-2810. |
| Aug. 9-Aug. 16, 1980 | Ophthalmology—U of S. CA Schl of Med., 2025 Zonal Ave., L.A., CA 90033. 28 hrs. Cat. I. Held at Mauna Kea Beach Htl., HI. |
| Aug. 14, 15, 16, 1980 | A Pan-Pacific Conf. on Tuberculosis in the 80s, Am Lung Assoc-spons. HI Thoracic Society. 245 N. Kukui St., Honolulu 96817. Held at the Ala Moana Htl., Honolulu. |
| Aug. 16-27, 1980 | 23rd Annual Post Graduate Refresher Course. USC, 2025 Zonal Ave., L.A., CA 90033. Held at Sheraton Waikiki, Honolulu; Maui or Kona Surf. Contact: Roy Labina-USC. |
| Aug. 16-Aug. 22, 1980 | Stress & The Physician—Honolulu Med. Grp. Research Ed. Found., 505 So. Beretania St., Honolulu 96813 (808) 537-2211, ext. 751. 22 hrs. Cat. I. Held at Hyatt Regency Maui Htl., Maui, HI. |
| Sept. 16, 23, 1980 | Gastrointestinal Radiology. San Diego Radiology Res. & Educ Found., Box 2305, LaJolla, CA 92038. Cosponsor-Am Coll of Radiology. Held at Maui Surf Htl. 4 days-30 hrs. Cat. I. |
| Sept. 16-18, 23, 25, 1980 | Advanced Cardiac Life Support Provider Course. HI Heart Association, contact: Skip Kirkwood, Program Director (808) 531-0174. 1301 Punchbowl St., Suite 203. 16 hrs. Cat. I. Fee \$150.00. |
| Oct. 3, 4, 1980 | Medicine in the 80's-State of the Art. 7:00-10:00 p.m.-10/3 9:00 a.m.-8:00 p.m. 10/4. |

Held at Prince Kuhio Htl, Waikiki. Spons. HMA-co-sponsor Unity Church of HI & UH Schl. of Nursing. Contact: John Watson, M.D. (808) 948-8585. 7 hrs. Cat. I.

Oct. 5-11, 1980 Recent Advances in Neurology-Spons: The Honolulu Medical Group Research & Education Found. & International Cntr. for Health Ed-Kauai. 25 hrs. Cat. I. Contact: Robt. M. Schmidt, M.D.-Internatl. Cntr. for Health Ed., P. O. Box 3109 Lihue, Kauai, HI 96766, (808) 245-2121. Held at Kauai.

Oct. 7-11, 1980 Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. I. Contact: Mary J. Rvals, P.O. Box 2305, LaJolla, CA 92038 (714) 459-9787.

Oct. 13-17, 1980 124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8-12noon. Contact: HMA office (808)536-7702 for further info.

Oct. 18-25, 1980 Western Orthopedic Assoc. Held at Hilton Hawaiian Village. Contact: H. Jacqueline Martin, Exec. Sec., 1970 Broadway, Oakland, CA 94612.

Nov. 3-5, 1980 Recertification Course for ACLS Providers-HI Heart Assoc. CPR Cntr. of HI, 1301 Punchbowl St., S 203, Honolulu. 8 hrs. Cat. I; Fee \$150. Contact: Skip Kirkwood, Prog. Dir. (808) 531-0174.

Dec. 11-14, 1980 Am. Med. Joggers Assoc. Contact: Hugh S. Ames, Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.

Dec. 14-20, 1980 Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



"IS IT CONTAGIOUS, DOCTOR?"



Minutes of Meeting Friday, May 2, 1980

HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Lum, Chinn, Iaconetti, Kam, Don, Hur, Lumeng, Morgan, Bruce, Cahill, Fong, Magoun, Wigle, Fu, Dang, Hellreich, Chang, Lee, Mr. V. Thomas Rice, and Mrs. May Kim. HMA staff present were: Mr. Won, Mmes. Kendro, Chang, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 6:00 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE TREASURER:

The February 1980 financial statement was reviewed in detail and approved subject to audit.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Medical Malpractice Insurance Crisis Committee: Dr. Phillip Hellreich reported that the committee has exceeded its goal of \$10,000 in pledges. The Committee recommended that Attorney James Kreuger be hired to proceed with the discovery and rate review proceedings against Argonaut.

ACTION:

It was moved, seconded, and passed to hire an attorney to proceed with the discovery and rate review proceedings against Argonaut, with any expenditures limited to funds actually collected from the pledgees. There were two opposing votes.

A slate of suggested attorneys was presented for Council's consideration. A motion to have the Executive Committee select the attorney was not passed. The Council requested further recommendations from the Committee regarding suggested attorneys.

B. Public Health: Dr. Thomas Cahill reported that the School Health Committee will meet shortly to discuss recent problems with head lice, as well as problems with Form SHS-20 (re, acceptability of history of

disease). The Cancer Committee will be formulating suggested health screening guidelines. With regard to the Medicaid Drug Formulary, Dr. Lumeng reported that the DSSH has published a first draft. The Substance Abuse/Pharmacy Committee, with input from specialty societies and various individuals, developed and submitted to the DSSH a summary of HMA's reactions and suggestions. A special meeting was held with DSSH representatives to convey physicians' concern relative to implementation of the drug formulary.

C. Legislation: Mrs. Becky Kendro reported that the legislative session has just concluded. After July 1, 1980, the Medicaid Program will utilize 1979 profiles as the basis for determining reimbursement to physicians. Physicians will be reimbursed approximately 79.5% of the 75th percentile. Passed this session was a generic drug substitution bill which if signed by the Governor, will become effective on July 1. In summary, the bill places the burden of responsibility for substitution on the consumer. Physicians will maintain the right to prescribe a specific drug, but the prescription must include the words, "Do Not Substitute" in the physician's own handwriting. Mrs. Kendro also reported that the Workers Compensation bill did not pass, however, a commission was appointed to review present laws and rules.

ACTION:

It was moved, seconded, and passed to request the Legislative Committee to prepare for report to the Council: (1) a list of bills that were not

passed this session, which are likely to be reintroduced, and (2) a list of general areas of concern where it would be beneficial for HMA to introduce its own legislation.

D. EMS: Dr. William Dang reported that the amended SDOH-HMA contract is presently being reviewed by the Attorney General's office. It was noted that HMA has been receiving payments from the DOH for services rendered by the EMS Program.

E. Jail Health Care Project: Dr. Walter Chang reported that a site visit of Kauai's jail was conducted, and the Committee is scheduled to make similar visits next week to the jails on Hawaii and Maui. It is anticipated that the Oahu Community Correctional Facility will make application to join HMA's Jail Health Care Program.

F. Computer: Mr. Jon Won reported that currently the major project is to complete programming for the BME in order that inhouse operations be started by July 1.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Calvin Kam reported that the HCMS is exploring the possibility of identifying Society members in the yellow pages of the phone directory. Since the Society will be striving to have its membership meetings focus on current issues, preliminary plans have been made to hold meetings with legislators, the DSSH, and the DEA.

B. Maui: Dr. Andrew Don reported that the Society recently presented a CME program on facial injuries. Mrs. June Morioka and Mr. Dave Nattenberg visited the Society to discuss the possibility of offering the services of the Physicians Exchange of Honolulu to Maui physicians. This month, Maui county physicians will be meeting with Mayor Tavares and plans are being made for an upcoming social event with legislators.

C. Hawaii: Hawaii County Vice President, Dr. Ben Hur, reported that the Society held a membership meeting with guest speaker, Dr. John McDougall, who made a presentation on nutrition. The Society held an international potluck with the proceeds designated for AMA-ERF. Dr. Hur reported that there are approximately forty physicians in the West Hawaii area of whom three are members of the Society. Since the Society would like to see more Big Island physicians involved in organized medicine and since it recognizes the geographic distance between the two groups of physicians, it was requested that efforts be made by HMA to contact the three West Hawaii HMA members to ask their assistance in exploring whether or not there is any interest in forming a county society in the Kona area. While the Council felt that the concept would need further study, it was agreed that the officers follow-up on this suggestion.

D. Kauai: It was reported that Dr. Bell, Mr. Won and Mrs. Chang attended the Society's April 19 membership meeting.

OTHER BUSINESS:

A. Pacific PSRO: PacPSRO President, Dr. Winfred Lee, reported that PacPSRO received continuation of

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funding through March 31, 1981 as a result of its recent site assessment. Another site assessment is scheduled for October 1980 to determine whether or not funding will continue beyond March 1981. Dr. Lee emphasized that PacPSRO will be seriously and objectively evaluating the quality of services rendered by physicians, that physician advisor decisions will be carefully monitored, and that the delegated role of a hospital will be largely assessed by responsible and objective physician advisor decisions. The Council agreed with PacPSRO's recommendations that for hospitalized patients, a physician's responsibilities include:

1. Admit for medically necessary reasons and discharge appropriately.
2. If prolonged stay is necessary and justified, appropriate level of care changes should be documented by the attending physician utilizing the Review Coordinator for consultation regarding criteria for levels of care; discharge planning should be initiated as soon as possible following admission.
3. Properly utilize ancillary services.
4. Obtain consultations as needed to expedite proper diagnosis and treatment.
5. Overall quality of care should meet the standards of our community.
6. Surgical and major medical procedures will only be performed when indicated.

A recommendation was made that HMA continue to support PacPSRO.

ACTION:

It was moved, seconded, and passed on to continue support of PacPSRO.

B. Auxiliary: Mrs. May Kim reported that in two weeks, the Auxiliary will present an AMA-ERF check for \$2,833 to the University of Hawaii Medical School. Mrs. Kim commented that the Auxiliary's benefit dinner on April 19 went quite well, with close to \$7,000 being raised for the Hawaii Medical Library.

C. Leadership Conference: Dr. Bell announced that the officers are proposing an HMA leadership conference in July or August 1980, with a view toward identifying HMA's missions and goals and to develop programs for achieving the Associations's goals. The Council concurred with the recommendation that a leadership conference be held prior to the next House of Delegates meeting.


D. Tax planning presentations: Mr. Jon Won reported that HMA has been approached by the firm Torkildson, Katz, Jossem & Loden regarding the possibility of conducting two tax planning presentations for HMA members. The proposed sessions would focus on two topics: (1) Incorporating a Medical Practice, and (2) Increasing Tax Deferral Through Defined Benefit Pension Plans. Tentative dates suggested were June 17 and 19. Members of the Council suggested that other dates be explored, such as a weekend or two consecutive days, to enable neighbor island physicians to attend.

ACTION:

It was moved, seconded, and passed to hold the tax planning presentations.

ADJOURNMENT:

The meeting was adjourned at 9:10 p.m.




**Clinical
Pathologist's
Easy Chair**

FRANCIS FUKUNAGA, M.D.

Bacteriology Specimen Collection

Collection of specimens for culture is a major problem for the clinical laboratory. Optimal information cannot be provided from improperly collected specimens, especially when they may be contaminated by the normal microbial flora.


One of the most common sites of infection due to bacteria is the urinary tract. Most infections are due to



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the enterobacteriaceae but some are caused by enterococci, streptococci, staphylococci and yeast.

Normal urine is sterile, but the distal urethra and periurethral regions may contribute many organisms to the properly collected specimen. This contamination usually is less than 10,000 and usually less than 1,000 organisms per ml. However, since these bacteria may have generation times as short as 40 minutes, the colony count can increase rapidly if the urine is not properly collected and handled. Infected urine contains more than 100,000 and usually 10^6 to 10^8 organisms per ml. However, infections due to the gram positive cocci may have counts of less than 100,000 (10^5) per ml. Patients on antimicrobial therapy will also have less than 10^5 per ml.

Urine cultures should be done within 2 hours of collection or the specimen must be refrigerated, but not longer than 24 hours. Voided urine for culture should be a midstream specimen after proper cleansing of the urethral meatus. Catheterization involves a risk of introducing an infection and usually is not indicated. Specimens from indwelling catheters should be taken with a needle and syringe close to the meatus after cleansing the tubing.

Cultures of respiratory tract infections are complicated by the normal microflora of the oral cavity and nasopharynx. Throat and nasopharynx cultures should be collected with a polyester swab and transported in Stuart's transport medium and cultured within 2 hours.

The normal flora of the throat, nasopharynx and paranasal sinuses include alpha streptococci, *Neisseria* species, *Staph epidermidis*, diphtheroids and a few yeasts. Some workers include *Staph aureus*, hemophilus species, pneumococci and some gram negative bacilli. The external auditory canal usually has *Staph epidermidis*, with occasional diphtheroids and yeasts.

Sputum and at least one blood culture should be examined in cases of suspected pneumonia. Sputum specimens are very frequently unsatisfactory and consist only of saliva. A suitable specimen should have less than 10 epithelial cells per 10x field or more than 25 WBC per 10x field, regardless of the number of epithelial cells. The specimen should reach the laboratory within 2 hours or be kept refrigerated. The normal (or usual) flora in the sputum is the same as in the throat. If properly collected, one sputum specimen per day is satisfactory.

Cultures for gastrointestinal infections are usually done to determine the cause of the diarrhea or to detect the carrier state. The stool specimen should reach the laboratory within 4 hours. Rectal swabs are satisfactory for acute diarrhea. The usual culture is examined for *Salmonella*, *Arizona* and *Shigella*. The physician should therefore alert the laboratory if he suspects any unusual infection such as *Yersinia enterocolitis*, cholera, *Staph pseudomembranous enterocolitis* or intestinal candidiasis. The enterotoxin should be demonstrated in the suspected food in *Staph*



HMA TO DEVELOP OUTLINES

A major new effort to improve cancer management is coming into being.

The HMA Council has agreed to enter into a formal agreement with the Community Cancer Program of Hawaii (CCPH) to construct, distribute and update outlines for cancer management.

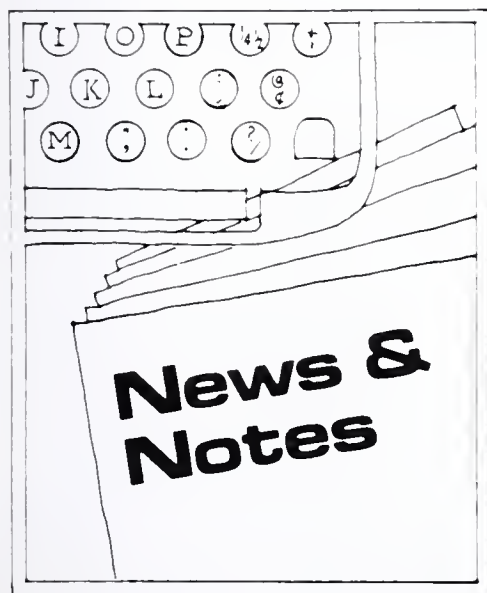
Many of you have been involved in the earliest stages of review of materials for these outlines. In order to have the best, clearest and most up-to-date outlines, your further assistance in reviewing materials will be necessary.

Anyone interested in participating in the review of these outlines, please contact John P. Keenan, M.D., or the Director's office of the Community Cancer Program, 548-8422.

food poisoning, and the suspected food should be cultured in suspected Clostridial food poisoning.

One specimen per day for 3 days is usually sufficient for parasitic infections except when a purged series is collected. In those cases where the diagnostic stage is not always present, such as Giardiasis and Strongyloidiasis, the 3 specimens should be collected over a 7 to 10 day period.

Closed wounds covered by an intact skin or mucosa such as abscesses should be cleaned and the material aspirated into a syringe. The most reliable cultures from open wounds are of biopsies or aspirates from the margins of the lesion.



HENRY N. YOKOYAMA, M.D.

Life In These Parts

A Helga Pedersson visiting from Oslo apparently watched the HMA TV program "Your Body, Your Mind" in which three bearded physicians participated, and was prompted to write as follows to the *Advertiser*: "I am visiting in your beautiful country. Everyone is very kind. I am happy to be here. I hope I stay well. Recently I saw on television some doctors speaking about cancer. They spoke very well and the program was interesting and helpful to me as my mother in Norway has cancer. I was surprised they looked so careless, with long hair and dirty looking beards on all. In my country, the doctors are the cleanest of all. I would not like to go to such unsanitary looking doctors even if they make such impressive speeches."

Fred Gilbert Jr., who apparently was one of the participants assuaged her fears as follows: "Re, hirsute doctors letter from Helga Pedersson of Oslo (4/18).

By the beard of a good king Harald, it is sad to know that Norwegian doctors are now beardless. It was not always so. It was not so when our Viking ancestors paid visits to the coastal regions from Vinland to Spain. It was not so when Roald Amundsen left medical school in Oslo to discover the South Pole. (Not only did he have a beard, but on the way back from the Pole, he ate his sled dogs, for which he was criticized for the rest of his life.)

Nor was it so when Nansen left the Fram and spent on foot and by Kayak attempting to reach the North Pole over the ice floes. Even Hansen, the discoverer of the cause of leprosy and the best known of all Norwegian doctors, went through life with a long beard. So fear not bearded doctors, dear lady, for they share a rich heritage with you."

Fred (Lund-Hammer) Gilbert Jr., M.D.

Sons of Norway, Snow Shoe Thompson Lodge.

Emmett Aluli, Hawaiian activist-physician, wrote the following dedication for a new "Na Mana'o Aloha O Kahoolawe"

(The Many Feelings of Love for Kahoolawe): "George Helm and Kimo Mitchell have gone holoholo, and left many of us confused and disappointed. Minamina, is the common reaction. Aikane or mohai ku are reactions of those closer to ka po'e kahiko. 'Aina 'e is a comfortable feeling." (As Bob Krauss, *Advertiser* columnist explains, "This new language seems to be one of the ways young Hawaiians are coming to grips with their dual heritage: Western and Hawaiian. It's a method of proclaiming their Hawaiianness while living in the Western culture, of expressing Hawaiian and haole feelings in the same breath."

McKenzie Park, a quiet, pine tree shaded seaside park, some 30 miles from Hilo on the remote lower Puna coast was where QMC medical resident **Philip Wolsk** and his fiancée went camping in April. During the night, Philip was clubbed to death and his fiancée critically injured. Professor of Medicine, Irwin Schatz, reported that Philip's friends and colleagues have contributed \$2,000 to a reward fund and commiserated, "It's just tragic. He was right at the beginning of his career. He loved Hawaii, he loved the people and was considering staying here."

HMSA reports that the average cost per day in community hospitals across the nation was \$222 in 1978. Locally it was \$252 or 13% higher, but a complete hospital stay averaged \$1,686 nationally, while locally it was \$1,159 or 31% lower. The average national hospital stay was 7.6 days compared to 4.6 days in Hawaii.

Prepaid Health Plans Gain Adherents . . . The Kaiser Plan has gained growing acceptance since its inception and today has over 100,000 members. More and more non-Kaiser groups in Hawaii are now offering pre-paid medical plans in cooperation with HMSA. HMSA has added its 12th and 13th clinics as members under its Community Health Program which now has 31,000 members and expects to have 40,000 members by the end of the year.

HMSA Executive Vice President Albert Yuen succeeded Donald Ching as president at HMSA's 42nd annual membership meeting in April. He blamed the dramatic overall increase in cost of health care (20% higher than 1978) on higher hospital charges. "Room and board charges increased almost 12% and ancillary charges for diagnostic tests, special care and therapy went up an average of 17%." Al reported that HMSA's membership rose in 1979 by nearly 13,000 to 528,362 and that HMSA processed more than 3.3 million claims and paid out \$141 million in benefits to its members. He also reported that HMSA has agreements with 871 physicians and 154 dentists throughout the State.

The Medical Examiner's office which has been without a qualified medical examiner since Alvin Majoska resigned in 1968 will finally fill the position with **Charles Odom** who is completing a residency in pathology at Louisiana State University and who has been studying forensic pathology on his own. Charles is a 1962 graduate of Tulane Medical School, served his internship at Queen's, went to Stanford for 3 years in OB GYN, joined the Honolulu Medical Group for a year, joined the UH Medical School Staff as a research fellow, then as an assistant professor and finally as associate professor. From 1971-73 he was director of postgraduate program in Okinawa then returned to Hawaii as associate dean of student affairs. (Ed. We can't think of anyone more qualified . . .)

In March, **Bill Goebert**, our neurosurgeon-lawyer, made an eloquent plea before the House-Judiciary Committee for passage of a Senate bill that would limit the hearing period of malpractice claims to 18 months, after which the parties could file suit. Under the present law, a suit cannot be filed until 60 days after a panel decision. Bill pointed out that 80% of medical malpractice cases in Hawaii since 1976 have been settled out of court, resulting in considerable savings to all parties. The cases have been settled by the Medical Claim Conciliation Panel which was established by law four years ago. However, the Judiciary Committee rejected the bill on Chairman Dennis Yamada's recommendation that "the mere fact of the statute of limitations won't speed up the process, and it may be detrimental." (Ed. To the lawyers no doubt)

North Kohala has 3,500 people and only one physician . . . **Charles Morin** had averted a serious medical problem by resuming private practice in the area when **Michael Padwick**

left to work for Ka'u Sugar Co. Without Charles, North Kohala would have been left with a hospital, but no doctor. Charles puts in a 45 hour week seeing 32 patients per day and then is on call an additional 60 hours a week. His Kohala Health Center contracted with the State to provide after hours and weekend emergency services, but until recently the State had not paid the stipulated \$3,000 per month. Charles set a May 1 deadline and the State finally came through, so Charles will remain . . .

The CHP and HMO's . . . The HMSA Community Health Program is bringing the HMO concept to Hawaii. CHP health centers on Oahu are the Central Medical Clinic, Haleiwa Family Medical Center, Medical Arts Clinic, North Shore Clinic, the Fronck Clinic, Straub Clinic and Waianae Coast CHP. On Hawaii, the Hilo Medical Group and Kona Medical Associates; on Maui, the Maui Medical Group; and on Kauai, Kauai Medical Group and Waimea Clinic. More recently 14 physicians in the Queen's Physician's Office Building have formed the Honolulu Physicians Program. It is the first time that individual physicians rather than a clinic have agreed to provide care for CHP members in CHP's eight year history . . . Of interest is that HMSA members who enroll in the Honolulu Physicians Program may select any one of the 14 physicians (regardless of their specialty) as their primary care physician . . .

Douglas Bell II, HMA president, announced that the HMA is one of the 24 states selected to participate in the AMA program to improve medical care and health services in jails. The Law Enforcement Assistance Administration (LEAA) of the U.S. Department of Justice selected the HMA which has appointed executive director Jon Won and governmental affairs supervisor Becky Kendro as co-project coordinators for the HMA Jail Health Committee consisting of project advisors: **Walter W.Y. Chang**, chairman; **Nadine Bruce**, **Albert Chun-Hoon**, **James Lumeng**, and **Neal Winn**.

Bulletins

Cas Jasinski, Regional Flight Surgeon, has sent a memo to all endocrinologists and diabetologists in Honolulu stating that patients on insulin or hypoglycemic drugs are disqualified for pilot duties by Federal Aviation Regulation Part 67. A recent aircraft accident on Oahu was apparently caused by insulin reaction in a 40 year old diabetic pilot who concealed the fact that he was on 20 units of Lente Insulin for the past two years. FAA accepts fasting blood sugars between 110 and 150mg %, provided these are maintained by diet alone. Insulin or hypoglycemic drugs are not permitted for pilots.

Address to the 1980 Graduating Class by Acting Dean John S. Wellington (Excerpts therefrom)

"You have been well trained in the science of medicine and you enter the profession at a time when major changes are in the offing . . . The first point I wish to make to you is to remember that in applying the science and technology of medicine, you are treating not disease or injury, but humans with personalities and emotions who suffer from disease or injury . . .

We recognize now that in the recent past, because of intensive specialization, the tendency has been to focus on the part with correspondingly less attention to the whole . . . This has not been good medicine and the public recognized it before the profession did.

It is necessary to maintain clinical detachment, but do not let this become an excuse for retreating into science at the expense of a human relationship with your patients . . . You cannot practice medicine without science—but the effectiveness of your science will in large measure be determined by the extent to which you are able to bring human understanding, support and compassion to the care of your patients and to communicate those qualities to them . . . The mental and emotional component of disease is well known and attention to that component is one of the physician's most effective weapons . . .

A second point I would raise deals with "accountability" . . . i.e. the sense of accountability to the general public . . . It is

difficult to think of anything more intimately involved with the human condition than medicine—yet there seems to be a widening gap between the physician and the general public . . . Specifically, in Hawaii there is virtually no understanding and appreciation of the impact of this medical school on the nature and quality of health care in the hospitals of Honolulu . . . To repeat: the public in general simply does not understand the medical profession . . . One thing laymen do understand, however, is that an increasing share of physician income, of physician training, or hospital construction and operation, and of medical research is paid for by the public tax dollar . . .

It is a simple and well known fact of life that he who pays the piper calls the tune . . . Medicine as a whole has not yet recognized this fact sufficiently and many continue to behave as if medicine were still a private matter, privately organized and privately paid for . . . But consumer groups and governmental agencies are increasingly asking questions, legitimate questions that must be answered, questions that imply change . . .

It would not surprise me in the least to see fundamental changes in the entire insurance and reimbursement mechanism for doctors and hospitals . . . Major changes in the method of reimbursement imply major changes in the entire organization and practice of medicine during the next 20 to 30 years and probably also in medical education itself . . . The change cannot be successfully resisted, although there will be those who struggle . . .

What is needed is a general acceptance that change is upon us and a cooperative spirit in bringing it about is the most effective way possible . . . Failure to do this could mean simply that medicine could forfeit any chance to have a voice and an influence on the new forms that are certain to come . . . As a first step, medicine must make a greater effort to explain itself, and I am not speaking of medicine as an institution, but of each of you as individual doctors . . . You must become participants and not antagonists. . . This is what I meant by the term "accountability". (Ed. We apologize for having to extract from a most enlightening message pertinent to all of us . . .)

Professional Moves

In this Year of the Monkey, *Homo sapiens medicus* has settled down to near hibernation the past two months . . . In April, the Waianae Medical Clinic Inc of internist **Ruben Mallari**, surgeon **Hermanio Mercado** and internist **Abdiel Angeles** relocated to 87-1644 Farrington Hwy in Nanakuli. In May, general and thoracic surgeon **Glenn Kokame M.D. Inc.** relocated to Suite 307 Kuakini Medical Plaza. On the Big Island, **William Orr** opened his practice at Captain Cook, in allergy, clinical ecology and acupuncture, and specializing in allergic and chronic diseases . . .

Sportsmen

The Racketeers . . . Our HMA sponsored team, with the simple original designation, "HMA" entered the Honolulu B league with team members, **Ben Chang**, **Worldster Lee**, **Ken Kern**, **Leabert Fernandez**, **Dennis Maehara**, **Gene Doo**, **Virgil Jobe**, **Jim Budde**, **Marc Szatz** et al . . . After the first few Sundays, HMA led their league with 9 wins and 1 loss. But alas! That was back in early May . . . By June 5, (according to Ken Kern), HMA stood 3rd in the section with 22 wins vs 13 losses . . . But undaunted they still hoped to win for the sectional playoffs . . .

Elected, Appointed, & Honored

Irwin Schatz, chairman of the Department of Medicine, John Burns School of Medicine has been elected to a three year term on the board of governors of the American College of Cardiologists . . . **Sharon Bintliff** and **Calvin Sia** are among the 12 delegates who will represent Hawaii at the White House Conference on Families to be held in Los

Angeles in July . . . **Gary Fujimoto** has been elected to Fellowship in the American College of Obstetricians and Gynecologists . . . The new officers of the Hawaii Chapter of the American College of Emergency Physicians are **Karl Pre-gitzer, Charles Mitchell, Eugene Kawaguchi, Lawrence Penner, and Lou Hefley** . . .

The Hawaii Transcendental Meditation Center honored **Wayne McKinney** for "his many years of service with Tom Dooley in South-east Asia and for his efforts to organize the Vietnam 'babylift' before Saigon was captured by the North Vietnamese in 1975." Wayne was one of five Hawaii citizens honored as individuals "who have spent their lives in out-standing service to their fellow men."

Life In These Parts

"Raising Cain (& Abel Too): The Parents' Book of Sibling Rivalry," (Wyden Books, \$9.95 hardcover) by **John F. McDermott**, chairman of John A Burns Medical School Psychiatric Dept. After five texts and 120 articles in medical journals, John has written a layman's book about what to do for sibling rivalry. His basic message is to use common sense in the light of information about stages of child development. The book is "breezy and informal and fairly peppered with anecdotes about brothers and sisters and their fights." John does not believe that families can function as democracies . . . that society has invalidated authority. He believes that par-ents need to function authoritatively and use authority reasonably. "We're all parents. We're all sensitive that our kids are extensions of ourselves. And then there's sibling rivalry. You can live with it, make it worse, make it better. But you can't stamp it out."

David Paperny who works in the Sex-Abuse Treatment Center at Kapiolani-Children's Hospital feels sex education as taught in the schools is ineffective. "Teachers are not the best people to teach sex. There is a much more effective way of teaching than to have an adult standing before a class of 30 giggling teenagers and blundering through a discussion on sexuality." David recommends discussion groups guided by clinicians trained in the field of sexuality.

Sharon Bintliff, Professor of Pediatrics, offers the follow-ing advice in "Making It As a Parent." "Children are not the only members of the family who grow and develop . . . Mothers and fathers also progress, through definite stages and experience many growing pains in the process. To know these stages is important, because communications and sens-ing feelings are critical to your adjustment in each stage . . ."

Stage 1—Learning the cues: This is the infancy stage—relating to and bonding with your child. Love begins here and must never cease for here begins the building of self esteem in your child . . .

Stage 2—Learning to accept normal growth and de-velopment: The parent who demands that a 3 year old tod-der be quiet, still and clean has got a real problem.

Stage 3—Learning to separate: This begins at about pre-school time and I'm not sure it ever ends.

Stage 4—Learning to accept rejection without deserting: This occurs in older school age and teens. What the children are communicating is overt independence but we take it per-sonally. They still need plenty of parental support, but it must be given as unobtrusively as possible, with respect for the child's feelings, pride and growing independence.

Stage 5—Learning to build a new life: This is really an extension of the previous stage, but we must build a new life without them. Mastering this stage is like frosting on the cake. Parents who get hung up in any of these stages always will have problems but especially this last one.

Everyone has a value system. Most of our values are religi-ous and cultural . . . Share your values with your children . . . Among all our values, none should be more dear than a renewed commitment to our children—and their parents. If they make it—then we've made it as a parent . . .

Physicians Speak Up

Back in Feb this year, **Neal Winn** had commented on the *Advertiser* article listing the names of physicians and their Medicaid earnings as follows: "We believe the publication of such a listing, serves no useful purpose other than to suggest that physicians, dentists and psychiatrists are solely responsi-ble for the soaring increases in the Medicaid program. If such disclosure of Medicaid earnings must be made, it would seem only appropriate to include the earnings of all segments of society who receive income from tax dollars whether it be social workers, landlords, government employees, etc.

Physicians share the concern of the Governor, the De-partment of Social Services, the Hawaii State Legislature and the citizens of this state that welfare costs are soaring and are willing to cooperate in seeking solutions.

We cite the 1978-79 Annual Report of the Medicaid Pro-gram prepared for DSS by HMSA which indicates that physi-cian services account for only 17.7% of the total services paid under the Hawaii Medicaid Program. Thus, reimbursements to physicians are less than one-fifth of the total picture. Many of those listed serve a population with a disproportionately high number of welfare recipients.

Physicians have long provided services at no cost to the medically indigent and even today subsidize the program by accepting less than their standard fees . . .

The HMA is fully behind these physicians who have dedi-cated themselves to serving the poor. We are willing and eager to assist the Legislature and the DSSH in stemming the problems arising from the large welfare population, compris-ing nearly 12% of our civilian population."

Of Hippies and Elephants . . .

(More of professor Mitchell's repertoire)

The woman hippie takes her LSD and her pill together so that she can go on a trip without kids . . .



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One hippie got LSD and LDS mixed up and went on a mission instead of a trip . . .

The circus stopped at a small midwestern town. During the night, a violent storm tore loose some of the cages and the animals broke loose . . . All the animals were soon rounded up except for Flossie, the elephant . . . In the morning, Mrs. Smith, who had led a sheltered dull life, looked out her kitchen window and saw this huge creature in her precious garden . . . She was frantic and called the police station . . . "Sergeant, there's a huge animal in my back yard." The sergeant inquired, "What's it doing?" "Well, it is pulling up my cabbages with its tail." "And what is it doing with the cabbages?" "Sergeant, if I told you, you wouldn't believe me!" she shouted . . .

Letters To The Editor . . .

We found interesting Lee Simmons' statement re Medicaid Problems: (Herein are excerpts therefrom)

"This state-run federally subsidized health care program (Medicaid) now covers 10% of the state's population . . . The state has consistently under funded the Medicaid program, paying only about 50 cents on the dollar for services rendered to Medicaid recipients . . . Medicaid started in the late 1960's paying doctors at reduced rates which remained fixed with no increase until 1975-76. At that point, many doctors started refusing Medicaid patients because the fees amounted to only about 35% of private charges. The state Legislature acted to bring reimbursement up to the 75th percentile of 1975 fees and promised to periodically update the fee schedule. No update has ever occurred.

Last year, acting at the last moment, the Legislature slashed \$15.2 million from the administration's biennial budget wiping out the first projected raise since 1975. Thus in 1980, doctors and dentists are still being paid their 1975 fees. The Legislature's action seems particularly short-sighted since half of that \$15.2 million would have come from federal co-payment.

Many serious inequities result from a five year old fee schedule. Doctors who started their practices since 1975 are reimbursed at a high level than physicians who have served longer . . .

Physicians and dentists on Molokai serve a population 25 percent of whom are under Medicaid. Many physicians in rural Oahu and on the Neighbor Islands are under extreme duress . . . Office visits are reimbursed at the same fee schedule by Medicaid whether the problem is simple or complex. A cardiologist receives the same reimbursement for a visit to a heart patient in a coronary care unit as for a routine hospital visit.

The crisis of 1975 is back with us and welfare patients will soon have difficulty getting care . . . The Legislature has refused to authorize the smallest co-payment that would make recipients more responsible for the care they receive. As a consequence, there are many broken appointments, visits to the emergency rooms for problems, doctor "shopping" etc.

There are very few constraints on medical care. Overall costs for the program continue to soar as demand for services continues to grow. When people are freed of economic responsibility for what they consume, be it goods, or services, they become wasteful and consumption increases steadily. Few people seem to recognize that free medical care can be consumed in excessive quantities . . . Inflation has given the state a \$150 million surplus. It would cost \$6.15 million of state funds (and matching federal funds) to pay providers in 1980 at the 75th percentile of 1978 fees. This is in effect the amount of indirect tax on health care providers and their paying patients."

Whenever our dear friend **Tom Frissell**, rebel-expatriate, social critic extraordinaire' writes a letter to the editor, we picture him grinning broadly from ear to ear and laughing heartily to himself:

In March, Tom wrote: "As our government-produced inflation continues unabated, anyone shopping at super markets will note the prices of hard liquor seem not to have risen at nearly the rate of other goods.

"It can be foreseen that the public will turn ever more to booze for both calories and solace.

"I, therefore, accuse our government of a conspiracy to turn us into a nation of alcoholics.

"The imposition of price control can only serve to hasten the process."

In April, he wrote: "A *Star-Bulletin* editorial April 5, and several others recently laud pre-paid medical care.

"If the argument that fee-for-service physicians will over-utilize is true, what will prevent those same physicians in a pre-paid plan from under-utilizing? Why will physicians be venal in one situation and not in the other?

"I find the editorial claim to be illogical. I personally do not believe the physicians operating under either situation to be more or less honest than the others. Proper preventive care could very logically increase the over-all cost; not decrease it.

"Also I find your argument that only Kaiser and HMSA are responsible for decreased utilization to be fallacious.

"Of far more importance is increased technology. Patients I would formerly hospitalize five or six days are now hospitalized one or two days. Others formerly hospitalized can be cared for at home, if the family is willing. Insurance plans have nothing to do with this. The reason is the tremendous increase in physicians' expertise and the above noted scientific technology."

Marathoner **John Wagner** makes a rather interesting point in his letter to the editor: "While young mothers are being gunned down in the streets while exercising with their young daughters, we are busy condemning President Marcos for his martial law. I suggest that we could use a little of his 'crisis management' ourselves.

Meanwhile, unprovoked violent attacks on innocent people are becoming commonplace in Hawaii. The Honolulu Police Department realizes this; let's hope our own legislature and judges finally take note."

John Corboy feels he has a legitimate beef about radar guns and governmental spending. He wrote: "The police Traffic Safety Division wanted some radar guns to control speeding, and now they have received a federal grant to buy 60 of these for \$600 apiece.

The police were unwilling or unable to spend their own money for these guns, possibly because of local outrage at taxpayers' money being spent for this purpose.

But when the money comes from Uncle Sugar, it's a quite a different matter. Federal grants mean 'free money' provided by nobody in particular. At a time when our nation falters on the brink of bankruptcy, it's depressing to realize that the president's 'bare bones' budget and Congress' 'austerity funding' nevertheless have enough fat left that our policemen can get \$35,000 for radar guns.

Multiply this small example by 10,000 others, and it's little wonder that nobody can balance the federal budget. Government is never the solution, gang. It's the problem."

Our "Angels"

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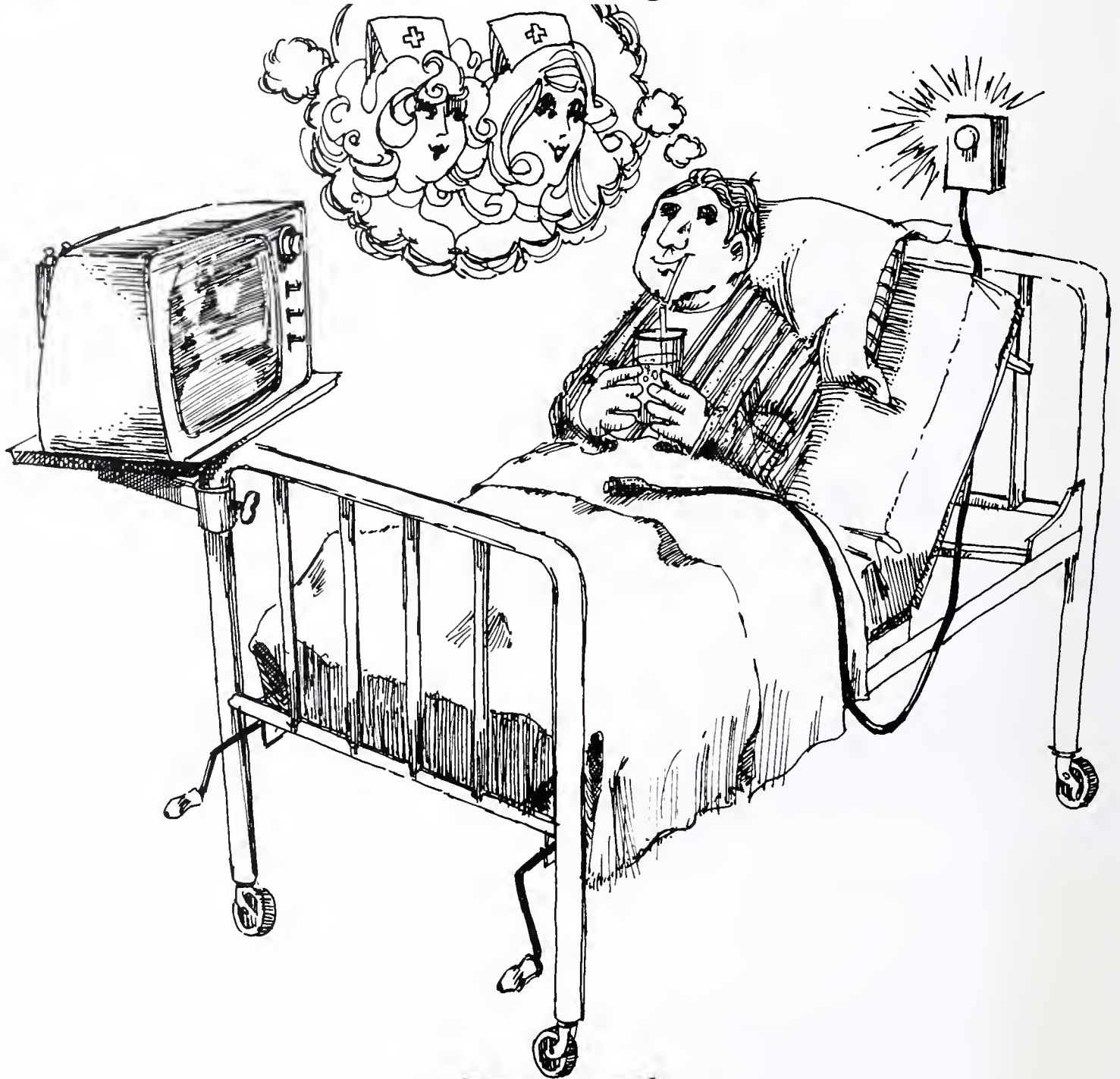
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JULY 1980
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Hawaii MEDICAL JOURNAL

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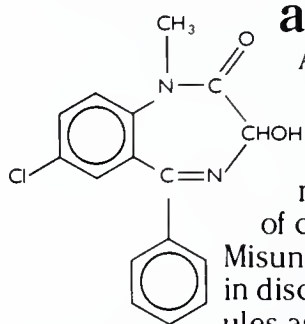
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Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.*

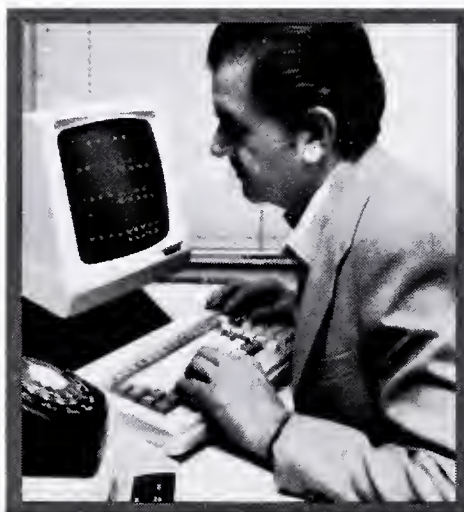
Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy.

Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they



learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms.

Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, et al: *Am J Hosp Pharm* 31: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders,

possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

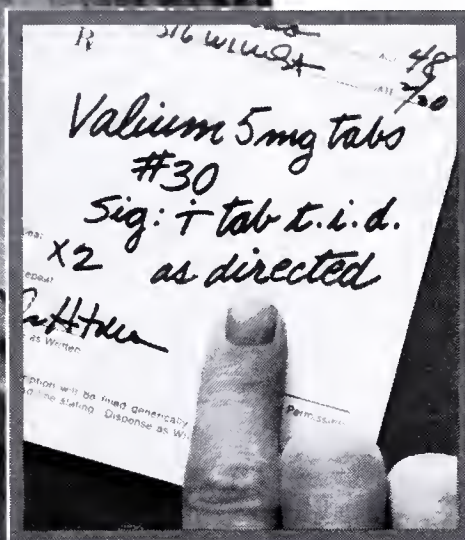
Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.



and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

2-mg, 5-mg, 10-mg scored tablets

Valium[®]

diazepam/Roche

An important adjunct to your treatment program for excessive psychic tension

Dosage: Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg i.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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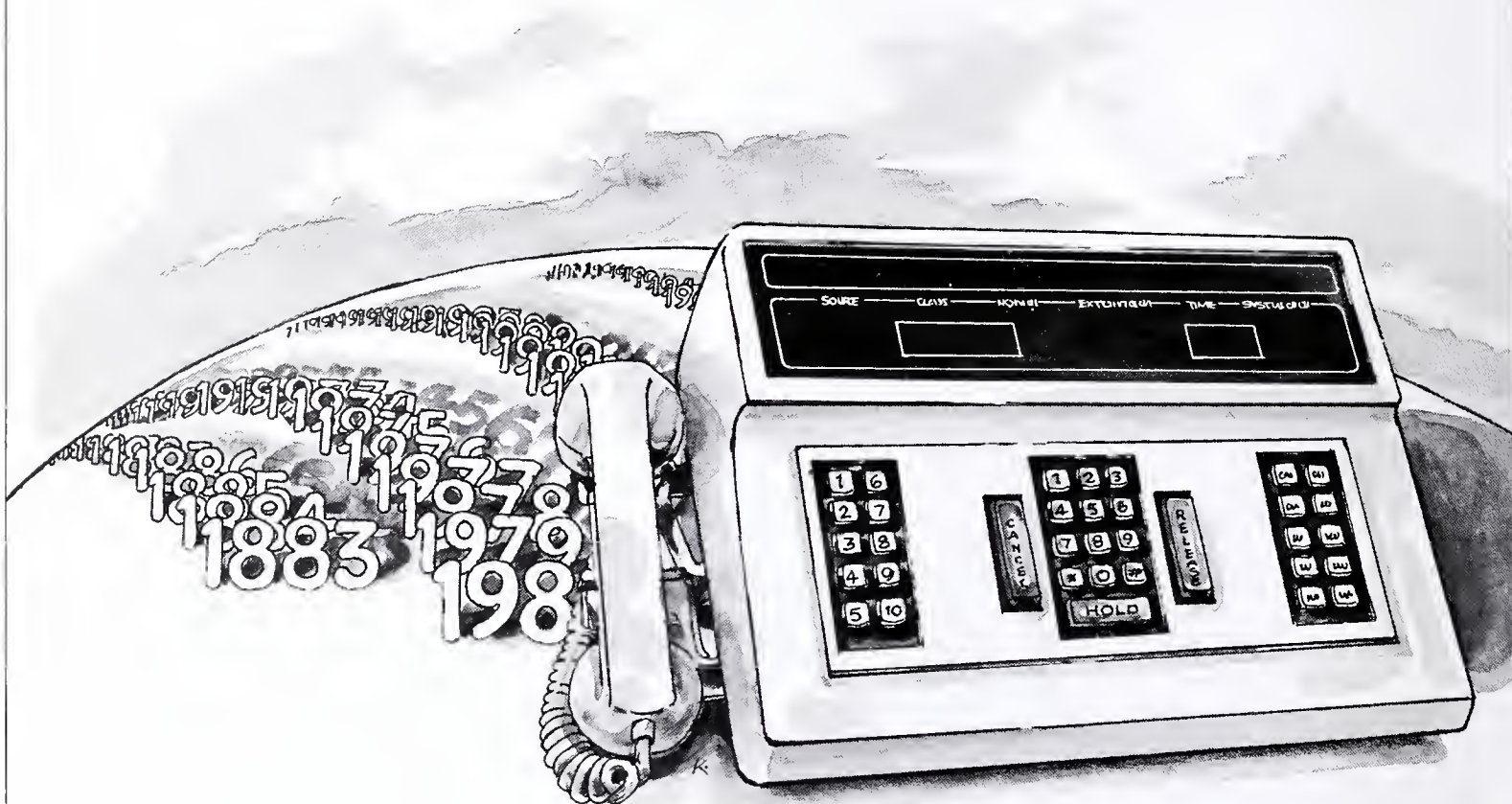


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barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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This is not an easy time for her to stop smoking.

But it's not a good time for her baby to start.

The facts are in.

FACT: Women who smoke during pregnancy have smaller and lighter weight full term babies.

FACT: Their babies have more respiratory problems during the first critical years.

FACT: The incidence of stillborn infants and neonatal deaths is significantly greater.

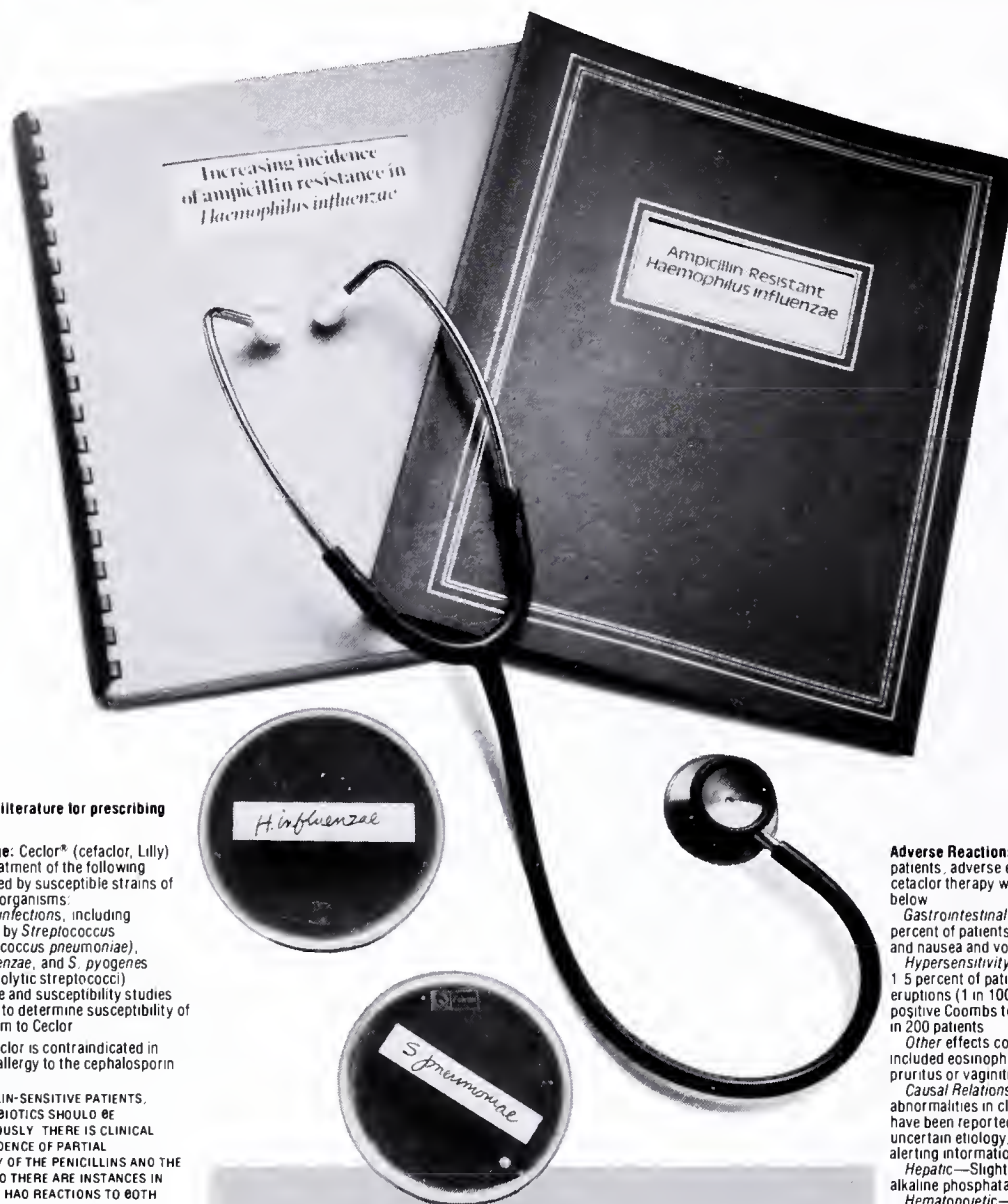
FACT: The fetal oxygen supply is significantly reduced—the carbon monoxide in the blood significantly increased. There's more. Much more.

Discuss the smoking hazard with your patients who are pregnant or planning a pregnancy. It may not be an easy time to quit smoking. But it's the right time.



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Office on Smoking and Health
Public Health Service Rockville, MD 20857

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy:—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy:—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain:—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁸

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C., American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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Clinical Concepts in the Management of the Respiratory Distress Syndrome in the Neonate

KENNETH ASH, M.D., RODNEY BOYCHUK, M.D., MICHAEL LIGHT, M.D.,
and DAVID EASA, M.D., *Honolulu*

Neonatal respiratory distress syndrome (RDS) or hyaline membrane disease is a disorder resulting from surfactant deficiency. Pulmonary surfactant, a secretion of type II alveolar cells, is composed of phospholipids, primarily dipalmitoyl phosphatidylcholine or lecithin, and functions to stabilize the air-filled alveolus against the collapsing forces of surface tension at the air-liquid interface.¹ Surfactant deficiency results in atelectasis, impaired gas exchange, reflex circulatory changes and alveolar transudation of protein rich fluids which organize into the eosinophilic staining hyaline membranes that give the disease its name.² Although most neonates synthesize adequate quantities of surfactant by 36 weeks gestation³ to prevent RDS, neonates born earlier than 36 weeks or those with delayed synthesis may develop RDS.

Through the work of Liggins and others,⁴ an understanding of the role of corticosteroids in induction of the surfactant system has evolved. Prevention of RDS is now possible through the administration of two doses of betamethasone given 24 hours apart to the pregnant mother of a fetus with immature lungs.⁵ However, despite this recent breakthrough, infants continue to be born with RDS. It is currently estimated that per year as many as 40,000 to 50,000 babies in the United States are affected by this illness.⁶ In Hawaii, approximately 150 babies with RDS are treated at the Kapiolani-Children's Medical Center each year.

Pre-term delivery is a major risk factor for the development of RDS.⁷ Pre-natal conditions associated with retarded lung maturity and RDS include maternal diabetes⁸ and severe erythroblastosis fetalis.⁹ Perinatal asphyxia may play a role in the development of RDS. There is an increased incidence of the disease in infants with low Apgar scores, in the second born of twins, and with maternal placenta previa.¹⁰ Increased risk of RDS also occurs in preterm infants delivered by Cesarean section before the onset of labor.¹⁰

The diagnosis of RDS rests on combined clinical and laboratory findings of prematurity, respiratory distress, a chest x-ray with air bronchograms and diffuse microatelectasis (grounding evidence of surfactant deficiency (negative amniotic fluid shake tests, or L/S ratio less than 2:1).³ The life of these infants depends on a team approach involving meticulous attention to details of circulatory and ventilatory changes and a thorough understanding of cardiopulmonary dynamics in the sick infant.

This paper will focus on certain bedside observations of the clinical course of the infant with RDS that guide the neonatal team at Kapiolani-Children's Medical Center in our approach to management. The following patient presentation, that of an infant with an uncomplicated course of moderately severe RDS, illustrates how management decisions relate to the time course of the illness. This case history represents a minority of RDS patients since of the 26 cases of RDS admitted to Kapiolani-Children's Medical Center from October, 1978, to January, 1979, inclusive, only 6 infants followed an uncomplicated course. A profile of the infants is seen in

Address correspondence to: David Easa, M.D., Assistant Professor of Pediatrics, University of Hawaii School of Medicine, Kapiolani-Children's Medical Center, 1319 Punahou Street, Suite #724, Honolulu, Hawaii 96826.

Accepted for publication January, 1980.

Table 1. The bias in the case selection is not a denial that the majority of infants with RDS develop complications. Rather, the study of the neonate with uncomplicated RDS furnishes insight into the disease through which the consequences and management of complications can be better understood.

TABLE 1.—Clinical Characteristics of 26 Infants with Respiratory Distress Syndrome

	UNCOMPLICATED GROUP N=6	COMPLICATED GROUP N=20
Birth weight		
Mean	1784 ± 418 grams	1910 ± 638 grams
Range	1200-2282 grams	1020-3639 grams
Gestational Age	33.2 ± weeks	33.3 ± 2.5 weeks
Hospital of Birth	Inborn-5 Transported*—1	Inborn-8 Transported*—12
Apgar Score<7		
1 min.	3	10
5 min.	0	5
Complications	0	Pneumothorax-5 Interstitial emphysema-4 Intraventricular hemorrhage-1 Suspected sepsis-1 Cleft lip-palate-1 Abruptio placentae-2 Death-0

*Infants born at other hospitals in Hawaii and later transported to Kapiolani-Children's Medical Center.

Case Presentation

Baby Girl E, a 2280 gram infant of 35-weeks gestation, delivered to a 19 year-old, Gravida-2, Para-O, AB-1, Caucasian mother after 5 hours of premature labor. The baby's Apgar scores were 7 and 8 at 1 and 5 minutes respectively. In the nursery, the infant had a heart rate of 160, respirations of 80 and systolic blood pressure of 54 mm Hg. Retractions and grunting were noted at 7 minutes of age and 40 minutes later, initial capillary blood gas studies showed a pH 7.23, pCO2 52 torr, pO2 30 torr in room air. A chest x-ray was compatible with RDS. Initially the baby was treated with 30% oxygen by hood. Oxygen requirements increased and at 4 hours of age, blood studies revealed pH 7.23, paCO2 54 torr, paO2 61 torr, in FiO2 = 0.6.

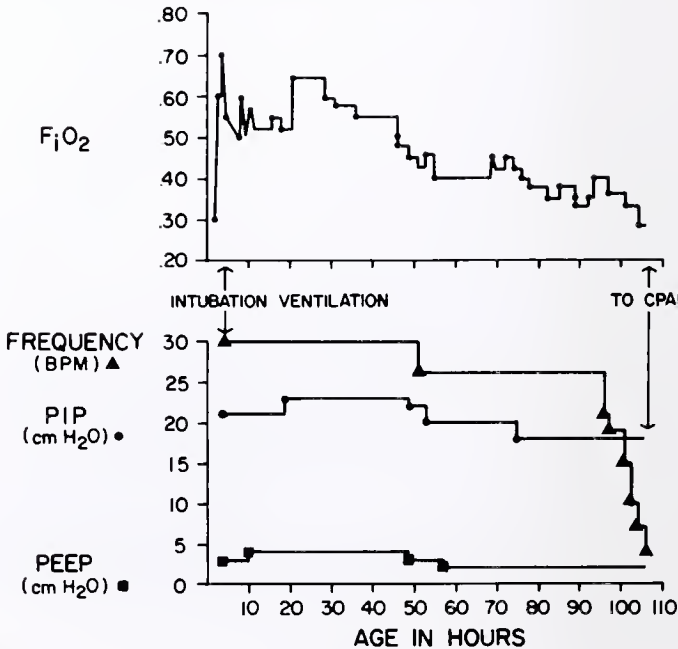
Because of increasing FiO2 requirements, the baby was intubated and stabilized with high-frequency positive pressure hand ventilation with an anesthesia bag at pressures of 25 cm H2O peak inspiratory pressure (PIP), 4 cm H2O positive end expiratory pressure (PEEP) and rates of 100 to 120. The baby's ventilatory support was then transferred to a Babybird ventilator at initial settings of rate 30, inspiratory time (IT) 1.0 seconds, PIP 21 cm H2O, PEEP 3 cm H2O and FiO2 = 0.7. The baby's respirations became less labored in synchrony with the ventilator and arterial blood studies showed pH 7.36, paCO2 40 torr, and PaO2 95 torr. A slow transfusion of 7 ml/kg of packed red blood cells was adminis-

tered. By 10 hours of life, the baby was stable on these settings with decreasing FiO2 requirements to .57 although the PEEP had been increased to 4 cm H2O.

Between 17-20 hours of life, the baby became unstable with FiO2 requirements increasing to .65 as the infant became restless and her respirations became asynchronous with the ventilator. She was sedated with morphine and the PIP was increased to 23 cm H2O. Arterial blood studies were pH 7.40, PaCO2 35 torr, PaO2 68 torr. At 29 hours the oxygen requirements again began decreasing. At 48 hours, the ventilator pressures were reduced to 22/3 cm H2O PIP/PEEP. Over the next 48 hours, oxygen and pressures were gradually lowered to .40 FiO2 and 18/2cm H2O PIP/PEEP respectively. Progressive decrease in ventilator frequency then led to weaning to continuous positive airway pressure (CPAP) at 108 hours. CPAP therapy was required until 120 hours of age when the baby was extubated, placed in an oxygen hood, and weaned to room air at 160 hours. She was subsequently discharged from the hospital on the 19th day of life, weighing 2240 grams.

Figure 1 represents the dynamic pattern of the disease in this patient. The infant presented shortly after delivery with the classic symptoms of respiratory distress—cyanosis in room air, tachypnea, grunting and retractions. Over 4 hours, she deteriorated into respiratory failure requiring mechanical ventilation. The institution of mechanical ventilation rapidly decreased oxygen requirements as adequate pressure and rate settings were selected through clinical and blood gas monitoring. This honeymoon period of stability abruptly ended at 17-20 hours of age when the disease process reached its height. This worsening, heralded by increasing oxygen requirements, necessitated higher mean airway pres-

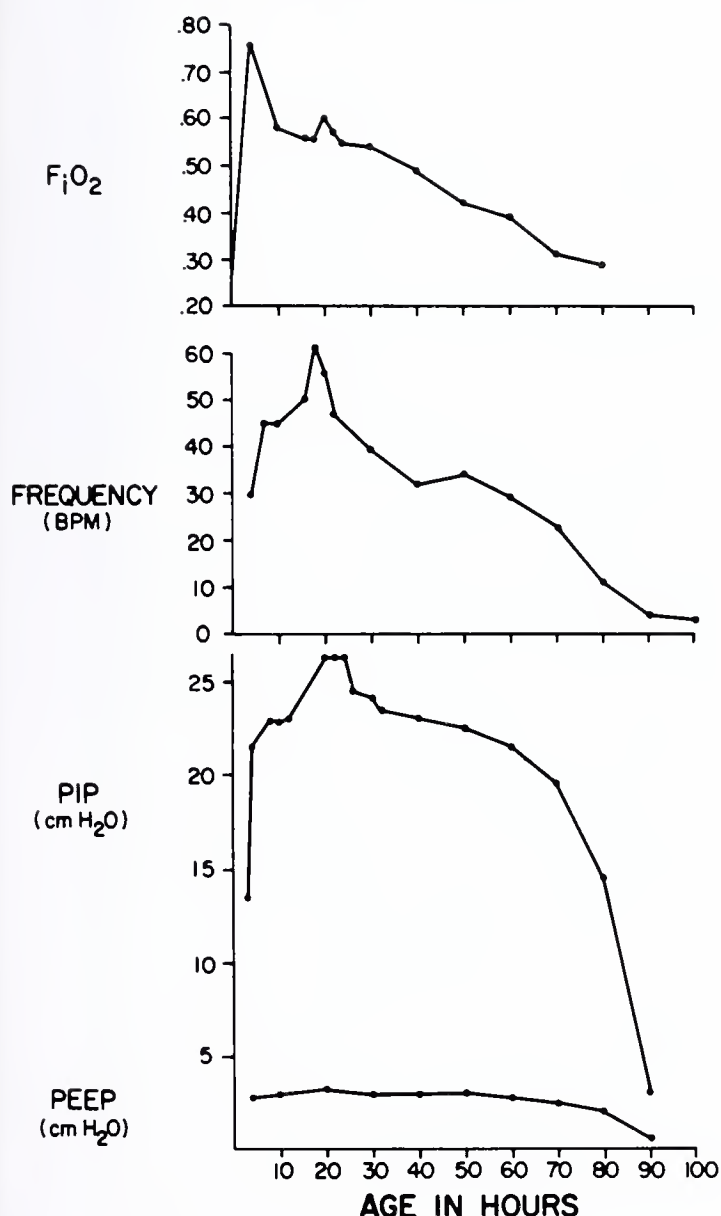
FIG. 1.—Ventilator requirements of a neonate with Respiratory Distress Syndrome.



tures. A new plateau of stability was then achieved at higher settings. Small but steady improvement ensued until a more rapid improvement began at 50 hours of age, leading to weaning from the ventilator at 108 hours of age.

When data from the 6 babies with uncomplicated RDS were integrated into a composite graph, a remarkably similar time course pattern emerged (Figure 2). We believe this general trend of early respiratory failure followed by stabilization, worsening and improvement represents the natural history of RDS. Let us then examine the relationship of this time course to clinical management.

FIG. 2.—Integrated data of ventilator requirements from six infants with uncomplicated Respiratory Distress Syndrome.



The Perinatal History

The care of the infant with RDS begins in utero with evaluation and monitoring of the high risk pregnancy, preferably performed at a regional perinatal center. There, evaluation of the mother and fetus through ultrasonography, serial estriol measurements, oxytocin challenge tests, amniotic fluid analysis, fetal heart rate

monitoring and fetal scalp blood sampling are available to guide the obstetrician in the determination of the optimal time of delivery. In light of Liggins⁴ work on glucocorticoid-induced maturation of fetal surfactant and the possible benefits of prolonged rupture of the fetal membranes,¹¹ we recommend the use of tocolytics to forestall an impending premature delivery. This is most important during the 48-hour induction period⁵ for fetuses of 28-34 weeks gestation, provided maternal and fetal well-being is not jeopardized. We also advocate the use of amniocentesis to assess fetal lung maturity before elective Cesarean section³ whatever the calculated gestational age. Fetal asphyxia should be avoided through continuous fetal heart rate monitoring throughout labor. Ongoing communication between the obstetrical and neonatal team is essential if adequate preparations are to be made for the impending high-risk delivery.

Initial Management

When the infant is delivered, the neonatal team is on hand to provide necessary resuscitation. Well-maintained equipment such as radiant warmers, suction devices, oxygen supply, endotracheal intubation materials, pressure-monitored anesthesia bagging apparatus, syringes, catheters, and resuscitation drugs should be in the delivery room at all times. The obstetrician should have a large heparinized syringe for obtaining blood from the placental side of the umbilical cord for use in blood volume expansion of the hypotensive infant. The depressed infant is promptly resuscitated to avoid the adverse effects of perinatal asphyxia on RDS.¹⁰

Since pressures seemingly benign for the larger neonate may overdilate the lungs of the tiny premature infant, discretion is used in applying only the minimum amount of ventilatory pressure necessary to restore cardiorespiratory integrity. For infants weighing less than 1500 grams, 10-15 cm H₂O peak inspiratory pressures (PIP) is a reasonable starting point. Minimum PIP of approximately 15-20 cm H₂O should be used for larger infants.

After stability is achieved in the delivery room, the infant is transported in a pre-warmed incubator to the Special Care Nursery with uninterrupted oxygen or ventilatory support. On arrival electrodes to monitor transcutaneous pO₂, ECG and skin temperature are promptly applied and vital signs taken. Next the umbilical artery catheter (UAC) is placed and hypotension is corrected with cord blood or albumin transfusion to interrupt the cycle of decreased pulmonary perfusion, atelectasis, acidosis and diminished surfactant production.¹² A blood Dextrostix is checked and IV glucose by push or infusion begun. Blood specimens for type and cross for whole blood, CBC, platelet count, blood culture and calcium are drawn through the UA

line as well as the initial blood gas determination. Chest x-ray, blood total protein¹³ and gastric aspirate shake test are ordered to support the diagnosis of RDS. Because bacterial pneumonia, including Group B streptococcal, is frequently clinically and radiologically indistinguishable from RDS,¹⁴ antibiotics are usually administered to infants pending culture results.

Respiratory Failure

Experience has shown that infants allowed to reach extremes of oxygen requirements, acidosis and hypercarbia before intervention, deteriorate markedly and require higher ventilatory settings. This increases the potential for all pulmonary complications. Conversely, unnecessary intervention raises the potential hazard of iatrogenic complications. Our premise is to begin ventilatory support when the PaO₂ is less than 50 torr in .60 FiO₂, PaCO₂ is greater than 55 torr, or pH less than 7.25 on two consecutive blood gas determinations.

As essential as blood gas criteria are, respiratory failure must also be appreciated as a dynamic process in relationship to post-natal age. In infants with uncomplicated RDS, the ventilatory requirements reach a maximum at 20-24 hours of age (Figure 2). The infant with early onset respiratory failure will require a greater degree of ventilatory support to assist him through the height of the illness. In contrast, the infant with the capacity to maintain adequate blood gases without assistance throughout the first 12-24 hours of RDS, will require comparatively less support through the peak of the disease.

The fragile premature infant less than 1500 grams is developmentally deprived of much of his capacity to compensate for mild-to-moderate RDS. One anticipates that modes of support which increase the work of breathing such as nasal CPAP^{15,16} may stress these babies and unnecessarily promote bouts of apnea and hypoxia. Therefore, one approaches tiny infants and those undergoing severe perinatal stress with the expectation that respiratory failure will develop early and will require mechanical ventilation. In contrast, premature infants greater than 2000 grams may require no more than oxygen by hood up to FiO₂ = 0.6. If their progression toward ventilatory failure proceeds slowly after 6-12 hours, some form of CPAP may support them through the worst of their disease. Regardless of birth weight, early respiratory failure is best treated with intubation and IPPV with a time-cycled pressure-limited ventilator.

The Phase of Stabilization

After determination of "respiratory failure," the infant is initially stabilized by high-frequency hand ventilation using rates of 100-140 BPM through a modified Gregory-type CPAP system

at pressures sufficient to move the chest wall, decrease dyspnea and improve blood gases.¹⁷ After 15-30 minutes of hand ventilation, the infant is transferred to a ventilator. Pressures needed to support the infant with the ventilator do not necessarily correlate with those used in the initial hand ventilation. All variations have been encountered. At times, 20-25 cm H₂O peak inspiratory pressures (PIP) may be required to move the chest with high-frequency hand ventilation, whereas the ventilator set on a slow rate, eg, 30 with a one second inspiratory time, may oxygenate and ventilate the infant at much lower pressures. In other infants, the high-frequency hand ventilation is more effective and much higher pressures on the ventilator may be required to achieve the same blood gas picture. Rarely hand ventilation is ineffective in stabilizing the infant and immediately switching to the ventilator produces rapid improvement.

In the initial ventilatory settings, we take advantage of the oxygenating ability of slow-rate long-inspiratory time-wave forms¹³ by using rates of 20-30 breaths per minute and inspiratory times of 0.8 to 1.0 seconds. PEEP's of 2-4 cm H₂O are generally adequate to maintain alveolar stability during expiration without causing circulatory embarrassment. The PIP is then the most critical variable. We start with a PIP range of 14-18 cm H₂O regardless of the pressures used during hand ventilation and assess the clinical effect of the settings.

Optimally, in intermittent mandatory ventilation (IMV) at ventilatory rates of 20-30 cycles per minute, the infant's spontaneous breathing is interposed as follows: (1) The ventilatory inflations should result in clearly visible although not excessive chest expansion. (2) As the ventilator cycle progresses toward mid-inspiration, the infant's respirations should decrease from shallow effort to respiratory arrest. (3) Spontaneous respirations resume in expiration with less dyspnea. This synchrony between the infant's voluntary respirations and appropriate ventilator settings is a reliable clinical sign of well-being, and almost invariably assures acceptable blood gases. Arrest of all spontaneous breathing suggests over-ventilation while continued dyspnea, struggling and weak chest expansion implies inadequate ventilation. When the initial pressure settings appear too low, the PIP is increased quickly in increments of 1-2 cm H₂O until the optimal pattern is achieved. Intermittent ventilation with an anesthesia bag may be necessary to restabilize the infant between pressure adjustments.

Throughout early stabilization, the transcutaneous pO₂ monitor provides an invaluable guide, although hardly a replacement for frequent arterial blood gases. The accuracy of the transcutaneous pO₂ electrode depends upon frequent calibrations and adequate skin perfusion and does not provide pCO₂ and pH values necessary for intelligent ventilator adjustments.

One strives to maintain PaO₂ values in the range of 50-70 torr, PaCO₂ 35-40 torr and pH 7.35-7.43. Physiologic consequences of deviations from these values are well documented. Low pH, PaO₂, and high PaCO₂ all predispose to pulmonary vasoconstriction,¹⁹ leading to atelectasis and impairment of surfactant production,² further increasing ventilatory requirements. Hypercarbia may predispose infants to intraventricular hemorrhage²⁰ and prolonged elevations may be associated with decreased intelligence.²¹ Hypocarbica decreases cerebral perfusion,²² increases airway resistance,²³ and oxygen consumption²⁴ and may lead to potassium depletion.²² The correlation between prolonged elevations of PaO₂ and retinal damage is well known.²⁵

If the infant fails to stabilize with PIP's in the range of 25-30 cm H₂O, the infant is sedated with morphine or paralyzed with pancuronium. Improvement may come without further pressure increases.²⁶ If the infant is refractory at slow rates of 20-30, rates of 40-120 with inspiratory:expiratory (I:E) ratios of 1:1 are then employed. Recently, criticism has been directed toward the use of high-frequency positive pressure ventilation (HFPPV) in infants with RDS, although at one time it was the standard mode of therapy.²⁷ Reynolds expressed his concerns about the reduced oxygenating ability of HFPPV and the high incidence of bronchopulmonary dysplasia among survivors.²⁷ Although he showed improved oxygenation with slower rates and increasing I:E ratios, he failed to study and compare the effects of 1:1 IE ratios at higher frequencies.¹⁸ We have repeatedly observed that higher frequencies with 1:1 IE ratios oxygenate infants well. Also, Reynolds did document the reduction in PaCO₂'s in babies ventilated at higher frequencies.²⁷

An important consideration justifying the use of HFPPV involves its effects on the circulation. Sjostrand has reviewed the literature on HFPPV and found minimal adverse circulatory effects,²⁸ which may be beneficial, since pulmonary vascular resistance is elevated in babies with severe RDS.²⁹ Both Rudolph¹⁹ and Fox³⁰ have shown the relationship between high pH, low PaCO₂ and pulmonary arterial vasodilation. One may speculate that the ease of control of pH and PaCO₂ with HFPPV, in conjunction with minimal adverse circulatory effects, may foster lowering of pulmonary vascular resistance and improve pulmonary perfusion in severe RDS. Furthermore, a recent report suggests that ventilating babies with RDS with slower rates and longer inspiratory times may be responsible for an increased incidence of air-leak complications.³¹

Studies by Heijman and Sjostrand,³² and Bland, Kim and Light³³ have reported success with high-frequency ventilation. We have found it possible to stabilize the infant with high frequency ventilation without further increases in

pressure.¹⁷ However, after shifting rate patterns, it is usually necessary to make further increases in PIP or PEEP to achieve final stabilization. Infants at FiO₂'s greater than .70 and peak inspiratory pressures greater than 30 cm H₂O are the most fragile and unstable, and must be observed continuously to prevent rapid deterioration.

Once stabilization of the infant is achieved, several conditions may disrupt the equilibrium between mechanical ventilation and spontaneous breathing, leading to labored and asynchronous breathing against the ventilator. Of these, manipulation, especially endotracheal suctioning, and bouts of crying are the most common. Sedative or paralyzing medications may be beneficial in reducing excessive agitation, but are not a substitute for elimination of all unnecessary handling of the infant.³⁴ Endotracheal suctioning at this early stage of the illness when secretions are scanty, should be performed infrequently and quickly with only one or two passes of the catheter. Air leaks and endotracheal tube dislodgement are infrequent causes of agitation in this phase of the illness, but should always be considered whenever there is an acute deterioration in the infant's status.

The Phase of Clinical Deterioration

Infants with RDS requiring mechanical ventilation for early respiratory failure must cross at least one additional hurdle before their recovery is assured. After initial stabilization, infants, as in our case presentation, decrease their oxygen requirements to between .40-.70 FiO₂. This depends upon the adequacy of ventilation and the severity of the RDS. At 20-24 hours of age (range 10-36) hours, the infant's condition will worsen with increasing oxygen requirements, accompanied by hypercarbia, and/or metabolic acidosis. This pattern of worsening resembles that seen experimentally in animals 24 hours after occlusion of one pulmonary artery, at which time minimal surfactant content of lung extracts and minimal lung compliance is noted.¹² The physician must be prepared to respond with maneuvers which increase mean airway pressure, lest he find himself chasing the PaO₂ to 100% oxygen or infusing inappropriate amounts of blood volume expanders and sodium bicarbonate in a vain attempt to stave off these consequences of decreased lung compliance.

These blood gas changes are often accompanied by subtle clues such as increased restlessness, decreased tolerance to suctioning or decreased chest expansion. Although sepsis, intraventricular hemorrhage, air leak, plugging or displacement of the endotracheal tube may account for acute deteriorations at this time, these should be swiftly ruled out so that appropriate ventilator changes are not deferred. Response to the height of the disease requires sedation and/or increasing mean airway pressure. Appropriate changes in increasing order of effec-

tiveness include: (1) Increase in total inspiratory time to a maximum of 35 seconds per minute (rate \times inspiratory time). (2) Increase in PEEP to 4-5 cm H₂O maximum. (3) Increase in rate to maximum 120 with I: $\frac{3}{8}$ ratio of 1:1. (4) Increase in peak inspiratory pressure as needed.

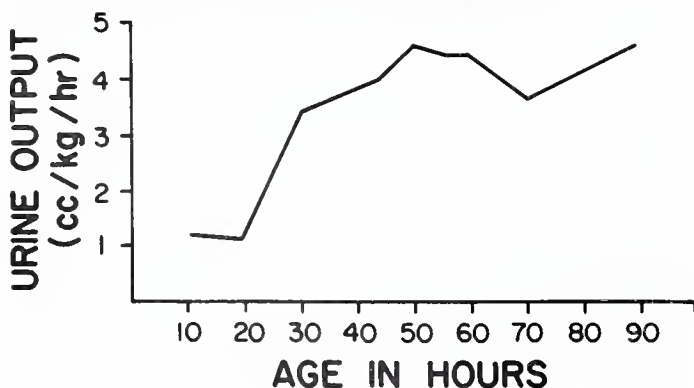
Interestingly, as ventilation improves, metabolic acidosis usually disappears. This may reflect the correction of accumulated oxygen debt secondary to hypoventilation.³⁵ Usually pressure increases of around 2-5 cm H₂O are sufficient to restabilize the infant, although some babies may require up to 10 cm H₂O additional peak pressure to tide them over the worst of their disease. After the infant restabilizes with improving blood gas studies and decreasing oxygen requirement, deterioration should remit, barring complications, as the infant moves toward the weaning phase.

The Phase of Improvement

At about 50 hours of age, rapid improvement ensues (Figure 1 & 2). This welcome event probably marks the emergence of surfactant production and parallels the time course of intrauterine maturation seen in the immature fetus induced by maternal administration of betamethasone.⁵ Serial tracheal aspirate phospholipid analysis of infants with RDS by Gluck and associates supports this hypothesis.³⁶

Ballard has documented that elevations in PaCO₂'s are associated with increasing plasma cortisol concentrations in the infant with RDS.² It is plausible that hypoventilation secondary to surfactant deficiency stimulates an endocrinologic response that promotes lung maturation in the ventilated infant. This might explain why post-natally administered corticosteroids fail to influence the course of RDS;³⁷ since the infant promotes his own surfactant induction at the onset of the illness and cannot be stimulated further by exogenous steroids.

FIG. 3.—Integrated data of volume of urine output in six infants with uncomplicated Respiratory Distress Syndrome.



This phase of improvement is heralded by increasing urine output (Figure 3), increasing chest expansion by ventilator insufflations, rising pH and PaO₂ and falling PaCO₂. Heavy sedation or paralysis should be discontinued at this time so that the infant may begin to assume a greater role in his own ventilation. Of utmost priority in this weaning phase is the gradual, but active reduction in PIP and PEEP. With increasing surfactant production, lung compliance will increase dramatically, and pressures appropriate for the height of the disease will now endanger the infant with over-distention and alveolar rupture. Ideally one strives to reduce PEEP to 2 cm H₂O for all babies and PIP to minimize values as follows: (1) Greater than 2000 grams—20 cm H₂O. (2) Less than 2000 grams—16-20 cm H₂O. In the early weaning phase, one may concomitantly need to support oxygenation by decreasing the ventilatory rate of babies on high-frequency protocols, while maintaining a 1:1 IE ratio with inspiratory times not to exceed 1.0 second. PaCO₂'s may for the first time in the illness be allowed to drift above 40 torr without fear of decompensation. Weaning may proceed in a regular 2-hourly schedule of rate reductions as long as pH remains above 7.30. The infant is weaned to minimum rate of 4, then extubated and placed into oxygen hood if greater than 1500 grams or treated with low-pressure nasal CPAP if smaller. In contrast to the stabilization phase, endotracheal tube suctioning should be done regularly and thoroughly during the weaning phase, as initially scanty secretions become copious. In the absence of pneumothorax or atelectasis, retarded progress or deterioration during the latter stages of the weaning phase most strongly suggests the presence of a patent ductus arteriosus. For management of this common condition the reader is referred to the comprehensive discussion by Merritt, Gluck and Friedman.³⁸

Conclusion

The management of the sick neonate with RDS has improved dramatically over the last few years. This is a result of a better understanding of the pathophysiology and clinical course of the disorder, coupled with better communication between pediatrician and obstetrician and significant advances in technology. Further advances are needed to improve the outlook of these infants.

REFERENCES

1. Strang LB: *Neonatal Respiration*, Oxford, Blackwell Scientific Publications, 1977, pp 82-105.
2. Tooley WH: Hyaline Membrane Disease, Telling It Like It Was, *Am Rev Resp Dis*, Voll 115, No 6, Part 2, p. 20, 1977.
3. Saunders BS, Kulovich MV, Gluck L: Antenatal Assessment of

- Pulmonary Maturation, in Symposium on the Respiratory System, *Clin Perinatal* Vol 5, No 2, Sept. 1978, p. 231.
4. Liggins GC, and Howie RN: A controlled trial of antepartum glucocorticoid treatment for prevention of the respiratory distress syndrome in premature infants, *Pediatrics*, 1972, 50, 515.

5. Ballard RA, Ballard PL, Granberg IP et al: Prenatal administration for prevention of respiratory distress syndrome, *J Pediatr*, Vol 94, No 1, Jan. 1979, pp. 97-101.
6. Scarpelli EM, Auld PAM, Goldman HS: *Pulmonary Disease of the Fetus, Newborn, and Child*, Philadelphia, Lea and Febigen, 1978, p 468.
7. Strang LB: *Neonatal Respiration*, Oxford, Blackwell Scientific Publications, 1977, p 194.
8. Ibid, p 196.
9. Boyle RJ, Oh W: Respiratory Distress Syndrome in Symposium on the Respiratory System, *Clin Perinatol* Vol 5, No. 2, 1978, p. 287.
10. Strang LB: *Neonatal Respiration*, Oxford, Blackwell Scientific Publications, 1977, p 195.
11. Yoon JJ, Hraper RG: Observations on the Relationship Between Duration of Rupture of the Membranes and the Development of Idiopathic Respiratory Distress Syndrome, *Pediatrics* 52:2, August 1973, pp. 161-8.
12. Tooley WH: Hyaline Membrane Disease, Telling It Like It Was, *Am Rev Resp Dis*, Vol 115, No 6, p. 22, 1977.
13. Bland RD: Cord blood total protein level as a screening aid for the idiopathic respiratory syndrome. *New Engl J Med* 287:9, 1972.
14. Albow RC, et al: A Comparison of Early-Onset Group B Streptococcal Neonatal Infection and the Respiratory Distress Syndrome of the Newborn, *New Engl J Med* 294:2, 1976.
15. Goldman SL, Brady JP, Dumpit FM: Increased Work of Breathing Associated with Nasal Prong CPAP, *Pediatr Res* 12:561, April 1978.
16. Nelson RM, Egan EA, Eitzman DV: Increased hypoxemia in neonates secondary to the use of positive airway pressure, *J Peds*, 91:1, July 1977, p. 87-91.
17. Ng KPK, Easa D: Management of Interstitial Emphysema by High-Frequency Low Positive Pressure Hand Ventilation in the Neonate. *J Pediatr* Vol 95, No. 1, pp. 117-8, July, 1979.
18. Reynolds EOR: Effects of Alternations in Mechanical Ventilator Settings on Pulmonary Gas Exchange in Hyaline Membrane Disease, *Arch Dis Child* 46:152, 1971.
19. Rudolph AM, Yuan S: Response of the Pulmonary Vasculature to Hypoxia and H⁺ Ion Concentration Changes, *J Clin Invest* 45:399, 1966.
20. Kenny JD, Garcia-Prats JA, Hilliard JL et al: Hypercarbia at Birth: A Possible Role in the Pathogenesis of Intraventricular Hemorrhage, *Pediatrics* 62:465-467, October 1978.
21. Hunt JV: Environmental risk in fetal and neonatal life and measured infant intelligence. In Lewis M (ed.): *Origins of Intelligence: Infancy and Childhood*. New York, Plenum Press, 1976, p 223.
22. Pollard B, Gibb DB: Some adverse physiological effects of hypocarbia and methods of maintaining normocarbia during controlled ventilation—a review. *Anaesth Intensive Care* 5:113, 1977.
23. Monkcom W, Patterson RW: Ventilation-perfusion inequities resulting from hypocapnic changes in lung mechanics. *J Thorac Cardiovasc Surg* 63:577, 1972.
24. Karetzky MS, Cain SM: Effect of carbon dioxide on oxygen uptake during hyperventilation in normal man. *J Appl Physiol* 28:8, 1970.
25. Committee on Fetus and Newborn, American Academy of Pediatrics: Standards and Recommendations for Hospital Care of Newborn Infants, 5th Edition, Evanston, American Academy of Pediatrics, 1971.
26. Stark AR, Bascom BA, Frantz 1D III: Muscle relaxation in mechanically ventilated infants, *J Pediatr* 94:439-443.
27. Reynolds EOR: Pressure-waveform and ventilator settings for mechanical ventilation in severe hyaline membrane disease. *Int Anaesthesiol Clin* 12:259, 1974.
28. Sjostrand U: Summary of Experimental and Clinical Features of High-Frequency Positive Pressure Ventilation—HFPPV, *Acta Anaesth Scand* 1977, Suppl. 64, 165-178.
29. Halliday H, Hirshfeld S, Riggs T, et al: Respiratory Distress Syndrome: Echocardiograph Assessment of Cardiovascular Function and Pulmonary Vascular Resistance, *Pediatrics* 60: 444-449, Oct. 1977.
30. Peckham GJ, Fox WW, Physiologic factors affecting pulmonary artery pressure in infants with persistent pulmonary hypertension, *J Pediatr* 93:1005-1010, Dec. 1978.
31. Engelka SC, Stein RT, Nicks J, et al: Ventilator Management and Pneumothorax in Neonates with RDS, *Pediatr Res* 12:560, Apr. 1978 (abstr.)
32. Heijam K, Sjostrand U: Treatment of the Respiratory Distress Syndrome—A preliminary report, *Opusc. Med Bd* 19, hr. 5, pp 235-244, 1974.
33. Bland RD, Kim MH, Light MJ, et al: High-Frequency Mechanical Ventilation of Low-Birthweight Infants with Respiratory Failure from Hyaline Membrane Disease, *Pediatr Res* 11:531, 1977 (abstr.).
34. Speidal BD: Adverse Effects of Routine Procedures on Preterm Infants, *Lancet* 1:864-865, Apr. 22, 1978.
35. Strang LB: *Neonatal Respiration*, Oxford, Blackwell Scientific Publications, p 175-176, 1977.
36. Merritt TA, Jacob J, Clarke TA, et al: Lung Maturity and the Patent Ductus Arteriosus: Why Ventilate the PDA?, *Pediatr Res* 12:564, Apr. 1978.
37. Baden M, Bauer CR, Colle E, et al: A controlled trial hydrocortisone therapy in infants with resp. distress syndrome, *Ped* 50:526, 1972.
38. Merritt TA, Gluck L, Higgins C, et al: Management of Premature Infants with Patent Ductus Arteriosus (Specialty Conference) *West J Med* 128: 212-222, March 1978.

Rotavirus in Newborn Nurseries: Negative Results From Honolulu and the New Hebrides

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● *A survey of 100 newborn infants in 2 newborn nurseries in Honolulu and 36 newborns in a hospital in the New Hebrides failed to reveal rotavirus infection, despite its presence in the surrounding community.*

Rotavirus infection in the neonatal period appears to be endemic in some nurseries in England and Australia, but absent from others in England, Australia, the U.S., and the New Hebrides. The infection is often asymptomatic in neonates. Rotavirus infection in the older infant (6 to 24 months) usually produces gastroenteritis and is common in both industrialized and non-industrialized countries. Whether prior neonatal infection with rotavirus is beneficial or detrimental to the older child is unknown. Longitudinal studies of rotavirus infections of children beginning at birth would be required to answer this question, and to explore the reasons for the uneven distribution of rotavirus among various newborn nurseries.

Rotaviruses are the most common cause of acute gastroenteritis in young children; over 50% of infants have been infected by the age of 2 years.¹ These viruses are prevalent during the winter months in the temperature zones and throughout the year in the tropics.² In children after the neonatal period, the presence of

rotavirus has a high correlation with symptoms—fever, vomiting, diarrhea and dehydration^{3,4}—although adult contacts of cases often have asymptomatic infections.⁵

In neonates, asymptomatic infection of a third or more of individuals appears to be common. In some newborn nurseries, infection seems to be endemic,^{6,7,8,9,10} but studies in other nurseries in the U.S.¹¹ and Britain¹² have not detected rotaviruses.

The present study was performed to ascertain the incidence of rotavirus infections in nurseries in a U.S. city—Honolulu—and in a less developed area—the New Hebrides.

Methods

Stools were collected from 2- to 18-day old neonates in nurseries of 2 different hospitals in Honolulu and from 3- to 5-day old neonates in a nursery in the New Hebrides from January to April, 1978.

The stools were diluted 1:5 with water, shaken with glass beads, centrifuged at 2100 r.p.m., filtered through 0.45 micron pore size filter, and centrifuged again at 35,000 r.p.m. (100,000G) for 90 minutes. The pellet was suspended in a few drops of water, applied to a 300 mesh Formvar-coated grid and stained with 3% phosphotungstic acid. At least 4 squares of each grid were examined at 30,000 magnification with a Zeiss EMU S-2 electron microscope. Some stools were re-examined, using the method of Murphy et al.⁶ and by direct (uncentrifuged) application of the specimens to the grids. All 3 techniques were tried initially on stools containing rotavirus and gave almost identical results.

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Results

Stools of 100 neonates from Honolulu and 36 neonates from the New Hebrides were examined. No rotavirus was found. During this same period, rotavirus was found in 8 of 34 older children with acute viral gastroenteritis in Honolulu and 10 of 16 children with gastroenteritis in the New Hebrides by the same techniques.

Discussion

There have been few studies of rotavirus infection in neonates in the United States. Our data and the data of Steinhoff and Gerber¹¹ indicate that rotavirus infection is not a "normal" occurrence in nurseries in upstate New York, Honolulu and the New Hebrides. Other studies⁶⁻¹⁰ indicate that rotavirus infection and gastroenteritis are a common finding in nurseries in England and Australia. In England, when nurseries in one hospital were monitored over a 1 year span, rotavirus infection rates varied from about 15 to 50%, depending on the season.⁷ Murphy et al. in Australia⁶ studied 6 different neonatal units, 5 of which had a continuing infection rate of 39 to 65%. Rotavirus was absent from the remaining nursery, but possible reasons for this were not given.

Differences in viral detection techniques or in age of the infants do not appear to explain our negative results. The stools of the Honolulu and the New Hebrides neonates were re-examined using the technique of Murphy et al. Several techniques were equally effective in detecting rotavirus in older children. The Honolulu neonates were 2 to 18 days of age (average 3.6 days) when their stools were examined. Murphy et al.⁶ found that by 2 days of age, their neonates had an infection rate of 37% and that most of the infected neonates were excreting rotavirus by 3 days of age. A prospective study⁸ from Australia showed that neonates had the onset of rotavirus excretion from 2 to 13 days of age.

Rotavirus was found in 25% of older children with gastroenteritis tested in Honolulu and in 60% of children with gastroenteritis tested in the New Hebrides during the period of this study. It does not appear that the absence of virus from the nurseries simply reflected conditions in the surrounding community. In 2 other negative studies^{1,12} rotavirus infection was also present in both the hospital and the community during the

period studied.

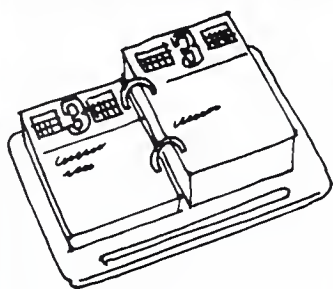
Varying nursery techniques might be responsible for the presence of endemic rotavirus. Bishop et al.⁹ found diarrhea to be common in nursery babies but unusual in those "rooming in" with their mothers. The Rochester study involved mostly infants in intensive and special care nurseries, in which special washing and growing techniques were observed. The Honolulu and New Hebrides nurseries contained mainly full-term newborns. One of the Honolulu hospitals practiced cohort isolation, with the infants regularly sent to their mothers for feeding. In the other hospital, rooming-in was encouraged with visiting limited to family members. In both hospitals, nursery personnel spent time in both the nurseries and in the maternity wings but were not used in surgical or acute care wings.

The immunological protection of breast milk may be a possible reason for a low incidence of neonatal gastroenteritis due to rotavirus infection. In one report,¹⁰ rotavirus excretion was less frequent in breast-fed babies. Symptoms were present in only 8% of those infected, but were more frequent in the bottle-fed group. In our study, 50% of the Honolulu neonates and almost all those in the New Hebrides were breast fed. The absence of rotavirus did not allow a comparison of rates in breast- and bottle-fed infants. In Honolulu, only disposable, commercially-prepared nipples and bottles containing standardized formula or water were used. In the New Hebrides, reusable bottles and nipples were used for water and formulas that were prepared in a central area.

Presumably an asymptomatic infection with rotavirus in the neonatal period protects a child against subsequent rotavirus disease of the same serotype, although second infection with a different serotype has been described.¹³ The reasons why infection is asymptomatic in a large proportion of neonates may offer valuable clues for vaccine development. The contributions of maternal antibody titer, differences among rotavirus strains, the dose and route of infection, and the response of intestinal mucosal cells at different ages remain to be defined. Long-term studies of newborns with and without neonatal infection, and of nurseries with and without endemic rotavirus would provide much information about this important human pathogen.

REFERENCES

1. Blacklow NR, Echeverria P, and Smith DH: Serological studies with reovirus-like enteritis agent. *Infection and Immunity* 15:63 (June) 1976.
2. Hieber JP, Shelton S, Nelson JD, et al: Comparison of Human Rotavirus Disease in Tropical and Temperate Settings. *Am J Dis Child* 132:853, 1978.
3. Rodriguez WJ, Kim HW, Arrobbio JO, et al: Clinical Features of Acute Gastroenteritis Associated With Human Reovirus-Like Agent in Infants and Young Children. *J Pediatr* 91:188, 1977.
4. Tallet S, MacKenzie C, Middleton P, et al: Clinical laboratory and epidemiological features of a viral gastroenteritis in infants and children. *Pediatr* 60:217, 1977.
5. Kim HW, Brandt CD, Kapikian AZ, et al: Human reovirus-like agent infection. *JAMA* 238:404, 1977.
6. Murphy AM, Albrey MB, Crewe EB: Rotavirus infection of neonates. *Lancet* 2:1149, 1977.
7. Chrystie IL, Totterdell BM, Banatvala JE: Asymptomatic endemic rotavirus infection in the newborn. *Lancet* 1:1176, 1978.
8. Cameron DJS, Bishop RF, Veenstra AA, et al: Pattern of shedding of two noncultivable viruses in stools of newborn babies. *J Med Virol* 2:7, 1978.
9. Bishop RF, Cameron DJS, Veenstra AA, et al: Diarrhea and rotavirus infection associated with differing regimens for post-natal care of newborn babies. *J Clin Microbiol* 9:525, 1979.
10. Totterdell BM, Chrystie IL, Banatvala JE: Rotavirus infections in a maternity unit. *Arch Dis Child* 51:924, 1976.
11. Steinhoff MC, Gerber MA: Rotavirus infection of neonates, *Lancet* 1:775, 1978.
12. Appleton H, Buckley M, Robertson MH, et al: A search for faecal viruses in new-born and other infants. *J Hyg Camb* (1978)81:279.
13. Fonteyne J, Zissis G, and Lambert JP: Recurrent rotavirus gastroenteritis, *Lancet* 1:983, 1978.



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John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

- B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. H1 Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respiro, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.

3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Monday Pediatric Seminar, 1:00-1:45 p.m. Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
5. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. G. I. Conference, First Tuesday, 8:00-9:00 a.m.
3. Depart. of Medicine Meeting, (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Endocrine and Metabolism Conference, every Wednesday, 7:30-8:30 a.m.
5. Nephrology Conference, Second Wednesday, 8:30-9:30 a.m.
6. Oncology Conference, every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, Third Thursday, 1:00-2:00 p.m.
8. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
9. Surgical Mortality & Morbidity Conference, Fifth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. Visiting Professor Program
2. Tumor Conf., Every Monday, 7:30-8:30 a.m. Sullivan 4—Classroom.
3. Renal Conf., First Monday, 1:00 p.m., Sullivan 4—Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Medical Board Room.

- *5. Department of Medicine Mtg., Second Tuesday, 7:30 a.m., Sullivan 4—Classroom.
6. Surgery Grand Rnds. First, Second, & Third Fridays, 7:30 a.m., Sullivan 4—Classroom.
7. Hematology Conf., Third Thursday, 12:30 p.m., Sullivan 4—Classroom.
8. Endocrine Conf., Every Fourth Monday 12:30 p.m., Sullivan 4—Classroom.

*For SFH Staff Members Only.

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

- | | |
|------------------------------|---|
| Aug. 9-
Aug. 16,
1980 | Ophthalmology—U of S. CA Schl of Med., 2025 Zonal Ave., L.A., CA 90033. 28 hrs. Cat. 1. Held at Mauna Kea Beach Htl., HI. |
| Aug. 14,
15, 16,
1980 | A Pan-Pacific Conf. on Tuberculosis in the 80s, Am Lung Assoc-spons. HI Thoracic Society. 245 N. Kukui St., Honolulu 96817. Held at the Ala Moana Htl., Honolulu. |
| Aug. 16-
27, 1980 | 23rd Annual Post Graduate Refresher Course. USC, 2025 Zonal Ave., L.A., CA 90033. Held at Sheraton Waikiki, Honolulu; Maui or Kona Surf. Contact: Roy Labina-USC. |
| Aug. 16-
Aug. 22,
1980 | Stress & The Physician—Honolulu Med. Grp. Research Ed. Found., 505 So. Beretania St., Honolulu 96813 (808) 537-2211, ext. 751. 22 |

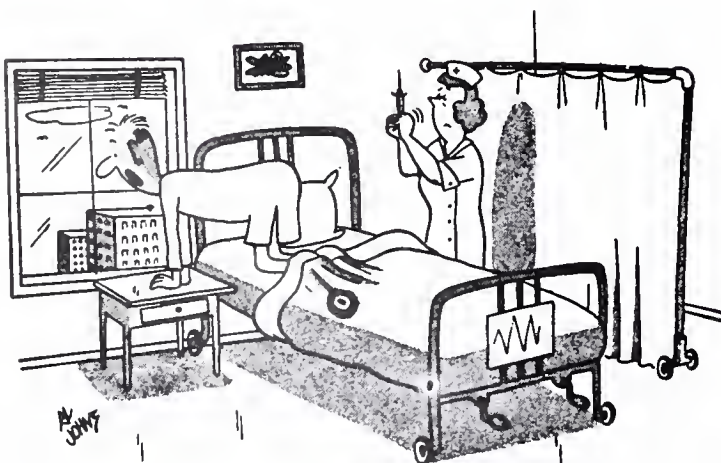
- hrs. Cat. I. Held at Hyatt Regency Maui Htl., Maui, HI.
- Sept. 16, 23, 1980 Gastrointestinal Radiology. San Diego Radiology Res. & Educ Found., Box 2305, LaJolla, CA 92038. Cosponsor-Am Coll of Radiology. Held at Maui Surf Htl. 4 days-30 hrs. Cat. I.
- Sept. 16-18, 23, 25, 1980 Advanced Cardiac Life Support Provider Course. HI Heart Association, contact: Skip Kirkwood, Program Director (808) 531-0174. 1301 Punchbowl St., Suite 203. 16 hrs. Cat. I. Fee \$150.00.
- Oct. 3, 4, 1980 Medicine in the 80's-State of the Art. 7:00-10:00 p.m.-10/3 9:00 a.m.-8:00 p.m. 10/4. Held at Prince Kuhio Htl, Waikiki. Spons. HMA-co-sponsor Unity Church of HI & UH Schl. of Nursing. Contact: John Watson, M.D. (808) 948-8585. 7 hrs. Cat. I.
- Oct. 5-11, 1980 Recent Advances in Neurology-Spons: The Honolulu Medical Group Research & Education Found. & International Cntr. for Health Ed-Kauai. 25 hrs. Cat. I. Contact: Robt. M. Schmidt, M.D.-Internatl. Cntr. for Health Ed., P. O. Box 3109 Lihue, Kauai, HI 96766, (808) 245-2121. Held at Kauai.
- Oct. 7-11, 1980 Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. I. Contact: Mary J. Ryals, P.O. Box 2305, LaJolla, CA 92038 (714) 459-9787.
- Oct. 13-17, 1980 124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8-12noon. Contact: HMA office (808)536-7702 for further info.
- Oct. 18-25, 1980 Western Orthopedic Assoc. Held at Hilton Hawaiian Village. Contact: H. Jacqueline Martin, Exec. Sec., 1970 Broadway, Oakland, CA 94612.
- Nov. 3-5, 1980 Recertification Course for ACLS Providers-HI Heart Assoc. CPR Cntr. of HI, 1301 Punchbowl St., S 203, Honolulu. 8 hrs. Cat. I; Fee \$150. Contact: Skip Kirkwood, Prog. Dir. (808) 531-0174.
- Dec. 11-14, 1980 Am. Med. Joggers Assoc. Contact: Hugh S. Ames, Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.

Dec. 14-20, 1980

Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.

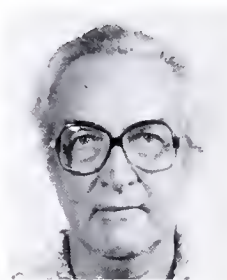


"I don't see any parade."

John D. Ainslie, M.D.

419 Waiakamilo Road
Honolulu, Hawaii 96817

PSYCHIATRY



Nathaniel P. H. Ching, M.D.

181 South Kukui Street
Honolulu, Hawaii 96813

GENERAL & THORACIC SURGERY



Kent Davenport, M.D.

550 South Beretania Street
Honolulu, Hawaii 96813

ORTHOPEDIC SURGERY





Friday, June 6, 1980

HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Hindle, Chinn, Iaconetti, Kam, Don, Lambeth, Chun-Hoon, Lumeng, Morgan, Bruce, Cahill, Newman, Wigle, Fu, Dang, Sia, Will and Mrs. May Kim. HMA Staff present were: Messrs. Ajifu and Saranchock, Mmes. Kendro, Chang, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 5:55 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of May 1980 which indicated that HMA membership totaled 937 as compared with a total of 904 as of May 1979. Also reviewed by the Council was a list of members who have been dropped from membership for non-payment of dues/capital fund.

REPORT OF THE TREASURER:

The March 1980 financial statement was reviewed in detail and approved subject to audit.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Medical Malpractice Insurance Crisis Committee: On behalf of the committee, Dr. Phillip Hellreich recommended that Attorney John Edmunds be hired to proceed with the discovery and rate review hearings against Argonaut.

ACTION:

It was moved, seconded, and passed to hire Attorney John Edmunds to proceed with the discovery and rate review hearings against Argonaut, with any expenditures limited to funds actually collected from the pledgees. There was one opposing vote.

B. Cancer Commission: Dr. Drake Will reported that the Hawaii Tumor Registry as well as the two portions of the Cancer Center program relating to demography and data computation were site visited in May by a

Blue Ribbon Committee of the NCI. Although a site visitation report has not been received, Dr. Will emphasized that in the next year, the Registry must demonstrate that its data is reliable and that significant progress has been made in computerization. Inasmuch as the HTR is part of the SEER program which could face some difficulty in the future, a recommendation was made that HMA should explore alternate methods of supporting the Registry should Federal funding be discontinued.

ACTION:

It was moved, seconded, and passed that the Cancer Commission explore potential alternate methods of funding the HTR.

C. Bureau of Research and Planning: Dr. Calvin Sia reported that the Bureau of Research and Planning had reviewed the composition of the Cancer Commission at the request of Council at its March 1980 meeting. The Bureau recommended that from 1981, the Cancer Commission be comprised of six members—two from the State Department of Health, two from the Hawaii Medical Association, and two from the Hawaii Division of the American Cancer Society; and that the Bylaws Committee be requested to draft the suggested amendments.

ACTION:

It was moved, seconded, and passed to direct the Bylaws Committee to prepare the above recommended amendments to the bylaws for submission to the 1980 HMA House of Delegates.

Dr. Sia reported that the Bureau has formed a subcommittee to study the concepts embodied in the recent Health Authority Bill and to consider Resolution No. 8 (re: establishment of a Hawaii Health Corporation) which was directed to the Bureau by the 1979 House of Delegates. A meeting was held with representatives of the Department of Agriculture and the UH Pesticide Department to discuss environmental problems with Kunia well. The possibility of conducting a research project on the effects of certain pesticides on children in the Kunia area, in cooperation with various groups, is being considered.

D. Legislation: Mrs. Becky Kendro presented a list of bills that did not pass in the 1980 legislative session which are expected to resurface next year, and a list of bills that HMA may consider introducing in the 1981 session. Council recognized that the upcoming leadership conference may help to identify other areas in which the initiation of legislation by HMA is desired.

E. Public Health: On behalf of the Cancer Committee, Dr. Cahill requested that Council adopt a policy for health screening programs as HMA is frequently asked to provide its endorsement or sponsorship. The committee regards the proposed criteria as a way of assisting the community to direct its resources in appropriate or beneficial manner.

ACTION:

It was moved, seconded, and passed to adopt for health screening programs, the following criteria which must be met prior to endorsement by HMA:

- 1) The disease must have a significant affect on quality or quantity of life.**
- 2) Acceptable methods of treatment must be available.**

WE KEEP THE MEDICAL PROFESSION IN TOUCH



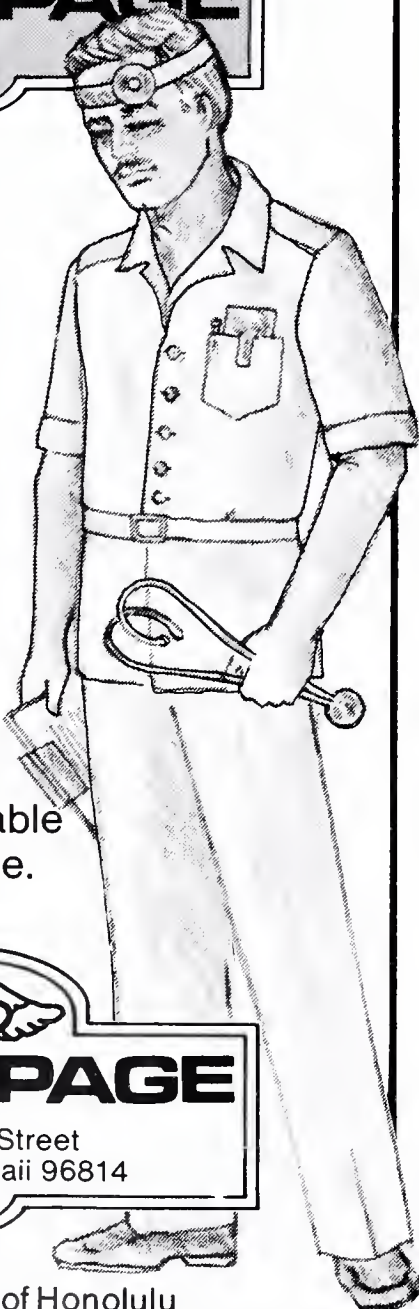
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- 3) The disease must have an asymptomatic period during which detection and treatment significantly reduce morbidity and/or mortality.
- 4) Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear.
- 5) Tests must be available at a reasonable cost to detect the condition in the asymptomatic phase.
- 6) The incidence of the condition must be sufficient to justify the cost of screening.

Dr. Cahill reported that the School Health and Communicable Disease Committees held a joint meeting with DOH representatives to discuss problems with the proposed School Health System Form 20 regarding the acceptability of history of disease for mumps and measles. The committees discussed the possible liability involved in requiring physicians to give immunizations when it is not medically indicated. A recommendation was made to DOH representatives that the old form be adopted which provides (1) that history of disease is *not* acceptable for rubella; and (2) that history of disease is acceptable for mumps and measles.

The School Health Committee recommended that HMA request the DOH to place head lice on the excludable disease list. It was pointed out that in the past, school health nurses were able to give children treatment in the school when they have had problems in complying with treatments at home. Since the school health nurses have stopped such treatments in view of possible liabilities, the Committee felt that some action should be taken to keep these children at home until the problem is alleviated in an effort to interrupt the cycle of the disease in school.

ACTION:

It was moved, seconded and passed that HMA request the DOH to place head lice on the excludable disease list.

F. Medical Education: Dr. Nadine Bruce reported that HMA's reaccreditation survey for CME has been scheduled for October 14 and that Dr. Sherrel Hammer has been assigned by AMA as the surveying physician. The Committee requested Council approval for the \$375 required reaccreditation survey fee for remittance to AMA.

ACTION:

It was moved, seconded, and passed to approve the \$375 reaccreditation survey fee.

G. EMS: Dr. William Dang reported that EMS has just completed a series of 30-second TV spots. The SDOH-HMA contract for the year ending June 30 is pending. Dr. Dang reported that Dr. Milton Howell from Maui has obtained a rescue vehicle and equipment and organized a group of approximately 15 volunteers to provide emergency response since there are no emergency services in this isolated area of the island. Inasmuch as Dr. Howell has requested assistance from the EMS program to train the volunteers and since his funds are limited, a recommendation was made that HMA fund transportation costs of \$300, if funds from other sources are not available, to arrange for the EMS program to present an EMT course in Hana, Maui.

ACTION:

It was moved, seconded, and passed that HMA fund transportation costs of \$300, if funds from other sources are not available, to arrange for the EMS Program to present an EMT course in Hana, Maui. There was one opposing vote.

H. Health Service and Care: Mrs. Kendro reported that SHPDA will hold public hearings on proposed rules for institutional appropriateness review. On June 20, the Community Health Care Committee will meet with SHPDA representatives to consider rules and regulations for Certificate of Need for ambulatory facilities. The Health Manpower Committee recently met with the former ANA president and Chairman of the National Joint Practice Commission. As a result of the meeting, the committee felt that it would like to encourage the formation of joint practice committees as a forum for discussing mutual problems.

I. Jail Health Care: Mrs. Kendro reported that during May the committee visited correctional facilities on Hawaii, Maui, and Kauai. A visit will be made to the Oahu Correctional Facility in the near future. The committee has planned a special meeting with guests from the Intake Service Center, Courts and Corrections Division, Ombudsman's office, etc.

J. Computer: Mrs. Kendro reported that HMA's computer now has the capability to print mailing labels of member and non-member physicians.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Calvin Kam reported that HCMS held a membership meeting on June 2 with guest speakers, Representative Herbert Segawa and Senator Pat Saiki, giving their views on legislation of the 80's. In July the Society will present a meeting on "DSSH Monitoring of Physicians, Facilities and Patients" with Dr. John Sheedy, DSSH Medical Consultant, as the featured speaker. Tentatively scheduled for August is a meeting with the Food and Drug Branch (Narcotics Division) of the DOH. On behalf of the HCMS Board, a recommendation was made that HMA consider establishing a committee on quackery. The Council discussed this matter but no action was taken.

B. Maui: Dr. Andrew Don reported that Maui County held its recent membership meeting with Mayor Tavares who spoke on water, sewage, insecticides, etc. In June the Society will meet with Mr. Bernard Ho to obtain an update on HMSA; and in July a meeting will be held with Maui legislators. Most recently, the Society established two committees which will focus on: (1) public relations (to form a speakers bureau which will provide speakers to community organizations), and (2) more local control of the hospitals.

C. Hawaii: Dr. James Lambeth reported that Mrs. Becky Kendro of the HMA staff met with the Society's Executive Committee in May to explain the new liaison program. On May 22, the Society met with the Vice Chairman of Shriners Hospital. The Society has also decided to form a legislative committee.

OTHER BUSINESS:

A. Leadership Conference: HMA's leadership conference has been scheduled for August 9 and 10, 1980, at the Ilikai Hotel. On the first day, there will be five reference panels which will receive testimony from

Mark Your Calendar



Hawaii Medical Association 124th Annual Scientific Meeting

October 13-17, 1980
Pacific Beach Hotel
Honolulu, Hawaii



members, non-members, and community organizations who have been invited to contribute their input.

B. Auxiliary: Mrs. May Kim reported that the Auxiliary held its annual meeting on May 15. Elected as 1980-81 officers of the HMA Auxiliary were: Mrs. May Kim (President), Mrs. Gwen Fu (President-elect), Mrs. Elisabeth Bell (Vice President), Mrs. Ella Edwards (Secretary), and Mrs. Carol McNamee (Treasurer). Mrs. Kim expressed her appreciation to Drs. Bell and Kam for their attendance at the annual meeting.

C. AMA Annual Meeting: HMA's delegation to the AMA will be in Chicago from July 20-24, 1980, to attend the Annual Meeting of the AMA House of Delegates.

MISCELLANEOUS BUSINESS:

A. Council Meetings: Dr. Bell announced changes in the Council's meeting calendar. Meetings will be held on July 11 and August 8.

ADJOURNMENT:

The meeting was adjourned at 8:45 p.m.

held no meeting that month, and these correspondents, who did not return in time to write the June Newsletter.

We have no **new members** to report this month, but **Darcel Gilbert** is transferring here from Phoenix, Arizona, and **James Koch** is back from New Mexico and practicing in Molokai. Also **Robert Freeman**, **Morris Hayes**, **Harold Lawson** and **Mark Wentworth** were reelected to active membership.

We express our heartfelt sympathy to **Homer Benson** who lost his wife **Kathryn**, when she died suddenly on June 13th while visiting relatives on the mainland.

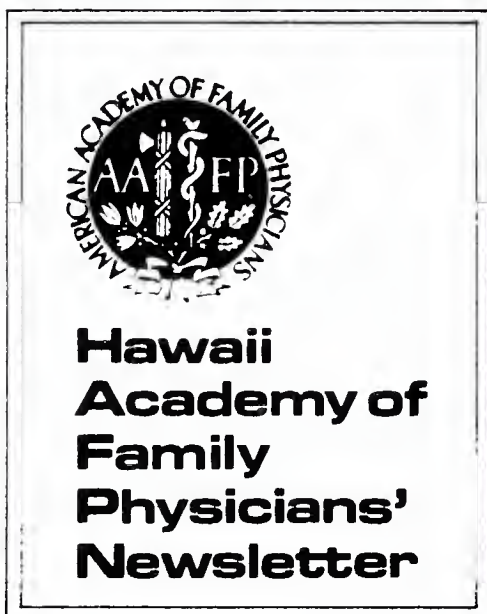
Our last **dinner meeting** was beautifully hosted by **Varian and Erna Sloan**, June 21. About 40 members and guests attended and heard presentations by **D. W. Soderdahl**, a Tripler urologist, on "UTI, infertility and Vasectomy"; and by **C. Sziklai**, a clinical psychologist, on "Stress Identification and Management".

The next dinner meeting will be held early in September. We will attempt to schedule future meetings to coincide with HMA meetings, so that our members from the outer islands may be able to attend both functions on one trip. Watch your mail for details.

At the recent UH Medical School convocation, **Fred Dodge** was presented the Golden Pineapple award as outstanding family practice teacher of the year. Fred has given many hours to precepting both medical students and residents and this honor is well deserved. Congratulations, Fred!

News of **FP residency programs**: Aloha to **Joe Fitzharris**, a member of our Executive Council, who finished his residency at Tripler and is leaving for Fort Belvoir, Virginia. Completing residencies with the Kaiser-UH program are **Al Chun** and **Ben Diniega**. Both are entering master programs in international health at UH School of Public Health. The residency program is entering its last year at Kaiser with three third year resident members, **Dave Gilmour**, **Lloyd Kobayashi** and **Marcia Sablan**. Further residency training in Hawaii depends in large part on strong vocal support of our members. Please call **Dean Rogers** office, as well as your friendly state legislator.

At its last meeting, the **Executive Council** passed a motion to oppose HMA's plan to designate its members by an asterisk in the yellow pages. Another motion passed supports George Mills as candidate for AMA Board of Trustees.



DON AND MARLIES FARRELL

It seems that May was travel month for members of the HAFFP, including the Executive Council, which

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HONOLULU COUNTY MEDICAL SOCIETY'S
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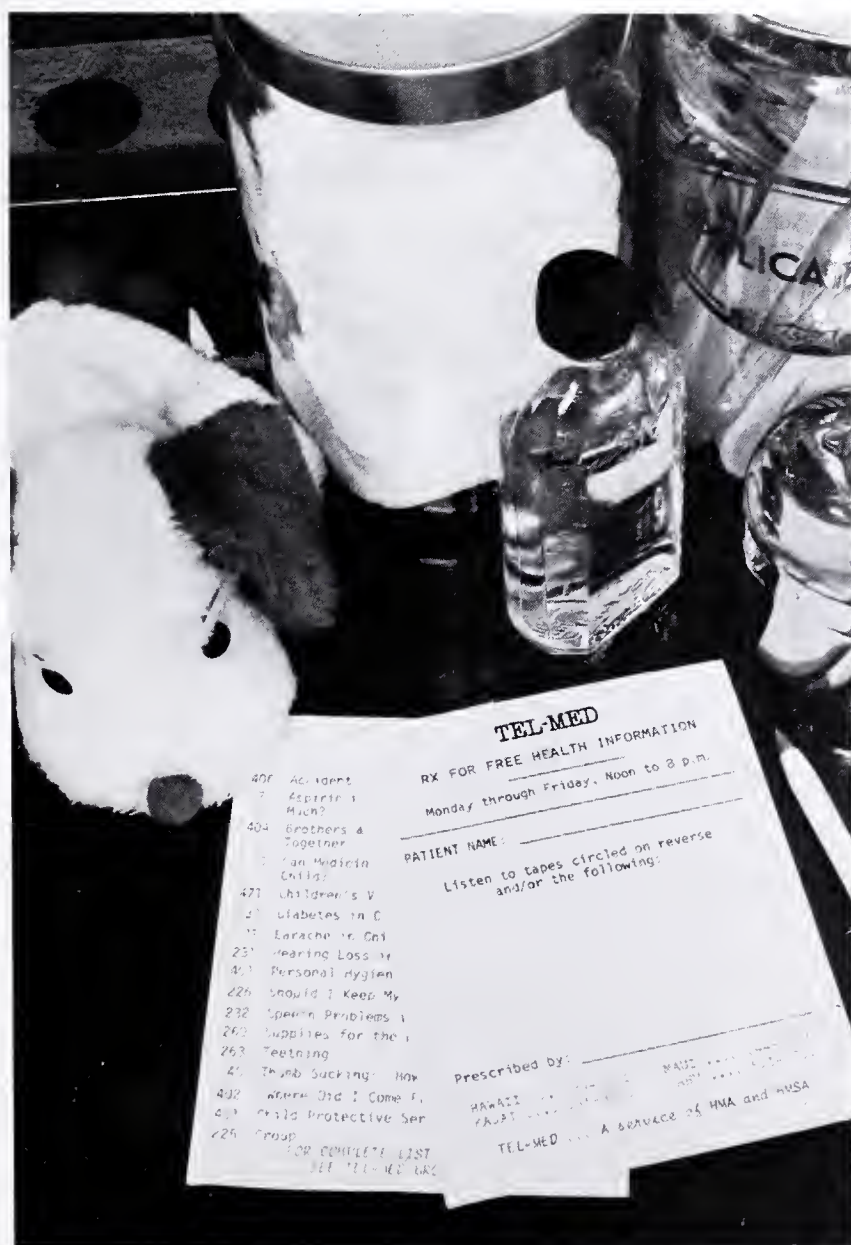
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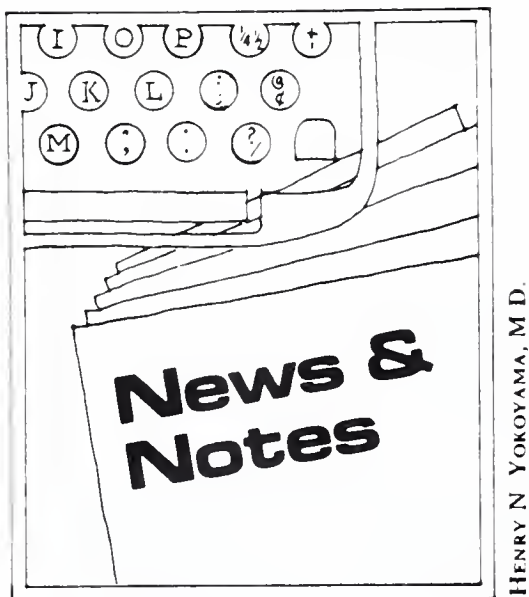
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Life In These Parts

Dermatologist **Claude Caver** recently had an HMSA claim returned with the terse comment: "Returned for date, place and cause of burns." Claude's original claim had read: "Curetted and desiccated keratoses, both side burns, each 3" square. 11423 . . ." Chagrined, but recognizing the humor of the situation, Claude replied: "Side burns are not chemical, thermal, or electrical burns. Side burns are the bands of hair which run from the scalp down in front of the ears to the jaws. They are named for General D. G. Burnside, a union general in the Civil War who wore 'side burns.'" (Sideburns! Ed.)

Pat Aiu, Kauai OB Gyn man, took a 2-month leave to sail to Tahiti and back on the *Hokule'a*. The Polynesian Voyaging Society's 60-foot, double-hulled sailing canoe set sail into a 5-day storm. Pat says: "The worst part was the constantly being wet and cold. We'd go to sleep in a wet bunk, get up in a wet bunk, stand watch in wet clothes. We never got dry, even when we were sleeping. Just as soon your body heat would warm up the water around you, another wave would come along. We were constantly doused with ice cold water . . . It was a time of really severe discomfort. It steeled the mind. It was a jelling sort of experience—everyone came together . . ." When asked if the trip had changed him in any way, Pat replied, "I think I'm a more tolerant person today."

A Sharon Bensley, who witnessed the TV spectacular of our neighborhood pharmacist friend, Take Torigoe (a truly honest and compassionate soul), being handcuffed and dragged to the police station by federal officers (for allegedly selling controlled substances to the same agent) wrote to the editor: "The list is growing of those in the medical field whose names have been dragged through the mud of doubt, perhaps never to be cleared. Suspected activity and unjustified claims of medical fraud hit the news media big and splashy, usually to wind down later to a quiet dismissal or acquittal with small publicity if any . . . Sensational pre-trial publicity is hard to avoid. But is worthy news coverage so hard to find that the news reporter has to follow police to film respectable, unlikely dangerous people being taken through the humiliating process of being arrested in the privacy of their own homes and handcuffed in full public view? A good reputation is important in the medical profession and the tarnishing of a profession plus the damage done to human dignity involved can be irrevocable . . ." (Ed. Methinks enough is enough . . .)

The reward is now \$7,000 for information leading to an arrest and conviction of the slayer of **Philip Wolsk**, promising Queen's Medical Center resident who was bludgeoned while camping at MacKenzie State Park in Puna, Hawaii in April. His fiancée Judy Panko who also suffered serious head injuries with residual partial paralysis in the same attack has returned to the mainland . . .

"Name Game: Dr **Terry Rogers**, UH med school dean, who has been on leave for a year for White House duties,

returns early next month. His sub here, Dr **John Wellington**, becomes associal dean for clinical affairs . . ." (don chapman Advertiser columnist)

Miscellany

The Secret Service entrusted with the president's security always makes sure that President Carter wears two pants when playing golf . . . So he won't get a "hole-in-one." (Claude Caver's witticism)

Hors De Combat

From Kokua Line (*Honolulu Star Bulletin* June 7): Q—"My doctor gave me the wrong prescription Tuesday and I got so sick I thought I was going to die! He gave me pills for high blood pressure instead of pills for my arthritis. I called him that evening and he told me to get rid of the pills and call him the next day. I'm afraid to call because he might wait for your answer."

A—"You should discuss this matter with your doctor. Tell him why you were afraid to call him and ask him how it happened, a Hawaii Medical Association official said. Patients are encouraged to communicate with their doctors. If you choose not to do this, call the Honolulu County Medical Society's 24-hour referral service, 536-6988. Three doctors will be recommended to you."

The Hospital Association of Hawaii's voluntary cost containment committee reported that total patient care costs in Hawaii hospitals increased 16.6 per cent over the first quarter of this year compared to the same period a year ago. Though the Consumer Price Index for all goods and services rose at a slightly faster rate of 16.8 per cent, hospitals held operating revenue increases to 12.5 per cent which was broken down as follows:

Salaries	17.3
Fringe benefits	28.6
Utilities	24.5
Food, drugs, supplies	13.3
Depreciation	11.8
Interest	10.5
Malpractice insurance	8.0

George Mills, committee chairman says, "In the future, we will be emphasizing further physician education about the cost of ancillary services in the hospitals. The physician makes 80% of the patient care decisions and is therefore a vitally important part of our efforts to contain health care costs."

Secretary Patricia Harris of HHS (Health and Human Services) announced that the government will begin a 2-year study costing up to \$2-million to determine the medical, social, economic and ethical impact of heart transplants. The study will determine whether Medicare should pay for heart transplants, which may cost from \$20,000 to \$100,000. She announced that HHS was ending a temporary program under which Medicare was paying for transplants at Stanford University where about half of all the world's heart transplants take place.

Sixty-two-year-old Wahiawa FP **David Tien**, convicted of Medicaid fraud, was ordered by Federal Judge Martin Pence to start serving his 30-day jail sentence on June despite cardiologist **Ed Chesne's** carefully worded letter that he feels Tien "can exist safely in a milieu where he can exercise modestly each day and where he can take his medications punctually. On the other hand, we feel that there is substantial risk to his life if a disturbance of this therapeutic program, namely modest exercise and the medications outlined, were to take place." Psychiatrist **Richard Trockman** recommended against jail time: "Dr Tien's great premonition of death and fear of imprisonment is to be regarded as somewhat of a self-fulfilling prophecy, as such cases are related after the fact. If Dr Tien were to be incarcerated at all, there is, in my judgement, a 50-50 chance that such incarceration would accelerate his paranoid symptoms, phobia and depression; if such acceleration occurs, it is then likely that he would thereafter become completely psychotic, perhaps deteriorating

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into a catatonic state." Apparently Judge Pence was unconvinced for he maintained that the request "borders on the frivolous." He also said, "The consequences of Tien going to jail are not so imminent that the sentencing should be stayed." After the hearing, Rich Eichor, State Deputy Attorney General and the prosecutor announced that David had repaid the federal government \$30,000 which was part of the plea agreement reached last December . . .

Kona physician **William Cooper** faces a possible 20 year prison sentence after pleading guilty to seven counts of providing dangerous and harmful drugs through prescriptions. Investigators from the State Health Department claimed William sold them Valium, secobarbital and other drugs without a legitimate medical reason. The 7th count was for issuing drugs without writing the DEA registration number . . .

Professional Moves

The anticipated deluge of announcements has not materialized . . . Perhaps it is still too early in this Year of the Monkey . . .

In June, the Kuakini Medical Plaza started to fill . . . Neurosurgeon **Maxwell Urata** relocated to Suite 302, the Hawaii Orthopedic Clinic (**Don Maruyama** and **Garth Morimoto**) relocated to Suite 309 and internist-nephrologist **David Yuan** moved to Suite 404. **Robert Thune**, allergist and immunologist joined the Straub Clinic and **George Chu** joined the Fronk Clinic. Internist **Theodore Harada** opened at Suite 804, Queen's Physicians Office Building. Internist **Thomas Au** opened at Rm 207, 181 South Kukui and OB Gyn man **Frank Nakamura** opened at Aiea Medical Building Suite 501. Dermatologist **Wm K. Wong** opened a branch office in Wahiawa Business Center (specializing in diseases of the skin, hair and nails) and on Maui, orthoped **George Zakaib** opened at Puuone Plaza, Wailuku . . .

In early July, allergist **Carl Lehman** relocated to 615 Piikoi, Suite 1411, and internist **Gary Inamine** joined Richard Inamine, MD Inc at 2658 So King St. Another internist **Gerald Soon** opened at Suite 706, 1380 Lusitana St. On the Garden Isle, cardiologist **Forrest Adams**, (former chief, pediatric cardiology, UCLA and past president, American College of Cardiology) joined the Kauai Pediatrics, Inc at Lihue . . .

Sportsmen

Dick "Aquaman" Tessoro speared a 25 lb ulua skin diving in 30 feet of water off Kalaupapa several years ago . . . (We can testify to this because we were there . . .) Now John Grant, Riker representative, informs us that Dick was skin diving off Lanai (his home town) in June and speared another ulua. Dick had quite a struggle and drank lots of water bringing up the ulua because he weighs a mere 145 lbs and the ulua 83 lbs . . . No fish story . . . huh?

Retired pediatrician-swimmer **Harold Sexton** (age 65) attended the 2nd World Medical Games in mid-June at Canne, France and came home with 4 gold and 2 silver medals. Earlier in May, he participated in the National AAU Short Course Masters Swimming Events at Ft Lauderdale, Florida and won 4 golds and 1 bronze. He broke two national records in the process . . .

Golfers:

The first tournament of the Hawaii Medical Masters Golf Class organized by **Dick Ho**, **Don Maruyama**, **Hideo Oshiro**, and **Allen Izumi** was held at the Waialae CC on May 30 and June 1 with 16 entries. The top five finishers were as follows:

Michael Okihiro	80-79-159
Richard Ho	79-81-160
Michael Piel	83-78-161
Hideo Oshiro	79-83-162
Allan Izumi	79-84-163

Dick Ho says, "The Hawaii Medical Masters Golf Classic was organized for the purpose of bringing championship golf to the medical profession. We hope to encourage golfing doctors to improve their game through scratch play tourna-

ments. At least, the best golfers in the profession will receive special recognition for their efforts. For the present, golfers with handicaps of 11 or less will qualify to compete in several tournaments scheduled for the year. We cordially invite other physicians who we inadvertently missed on our talent search to join us."

Runners:

The Honolulu Marathon Clinic's weekly Sunday program featured "Women's Day at the Park" and president **Jack Scaff** was on hand to explain the difference between male and female athletes. Jack said, "The problem with women in sports, is that it's really been a man's world . . . Women have been relegated to a back seat position . . . While the dangers to women in long-distance running have been proved mostly fallacy, there are certain basic differences between the male and female athlete . . . One of the biggest is the physiological, with the existence in men of the hormone Androgen which makes men's muscles about five to ten percent stronger and causes them to bulk up . . . Beyond that, there really is no difference between male and female athletes." Jack also pointed out that the menstrual cycle is in no way related to category of performance, but during periods of stress (such as heavy training), the cycle tends to stop . . . Hyperthermia might cause fetal abnormality during pregnancy, but literally hundreds of thousands of women run and exercise regularly and have normal healthy children . . . With weight loss comes a change in mobilization of fat; therefore, women will notice a decrease in chest size, as well as elsewhere.

Elected, Appointed, & Honored

Straub physicians, **W.F. Haning, III** and **Norman Nakashima** were recently inducted in the American College of Emergency Physicians . . . Pediatricians **Francis Riggs** (who recently received a masters of public health degree from

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UC Berkeley) will replace **Jeremy Lam** (who is entering private practice) as head of the School Health Services Branch of the state Department of Health . . . **Albert Chun-Hoon**, **Ruben Mallari** and **George Goto** were appointed to the Board of Medical Examiners . . . **Donald Char** was appointed to the State Board of Health . . . **John Ohtani** was appointed to the Statewide Health Coordinating Council . . . **Robert Lee** and **B.E. Realica** were appointed to the Medical Advisory Board . . . **Sherrel Hammer**, chairman of the department of pediatrics, UH Med School was elected medical advisor of The Hawaii Mother's Milk Bank, a nonprofit corporation which provides hospitals with human milk for hospitalized infants with critical feeding problems . . .

The Hawaii Society of Internal Medicine elected **Robert Nordyke**, president, **Bernard Fong**, president-elect, and **John Kim**, secretary-treasurer . . .

Queen editor, **Harry L. Arnold, Jr.**, was appointed Consultant Emeritus to Tripler Army Medical Center in May.

Physicians Speak Up

W.F. Haning, III griped "Unauthorized by law, and against common sense, George Ariyoshi proposed to rebate \$50 per taxpayer, exemption and resident. He predicts a surplus, in a state whose Crippled Children's Service cannot meet the needs of its clients, and whose Medicaid program defrauds the medical profession; at a time when Cincinnati, Chicago, Philadelphia and New York are bankrupt or threatening same.

His tax service spends great sums collecting money from me, on a schedule proportionate to my income; now he will waste more of my tax money returning an equal (and thus disproportionate) share to everyone in town, on or off the tax rolls."

John Corboy wrote the following letter to the editor: "On Jan 27, our enlightened planners of the Hawaii State Health Coordinating Council (HSHCC), the State Health Planning and Development Agency (SHPDA), and their Sub Area Councils (SAC's) spent \$5,000 of the people's money on a two-page spread in the Sunday paper. They tried to explain the State Health Plan (SHP) and also about Proposed Use of Federal Funds (PUFF) and Certificates of Need (CON).

We asked a dozen neighbors what the ad said. The three who had managed to read it couldn't explain HSHCC, SHPDA, or SAC. When we asked the other neighbors to read carefully, they couldn't explain it either, except to say that it seemed like a lot of agencies were spending a lot of money counting and planning and justifying their jobs. "It's all CON and PUFF, anyway," said one neighbor, admitting he couldn't tell a SHP from a SAC.

I suppose it's not easy to explain, much less to justify all of this expensive bureaucracy. But it seems that health planners, entrusted with the public's hard-earned money, could have better spend that \$5,000. It'd buy a lot of care for sick people."

John Wagner of the Honolulu Marathon Clinic wrote thusly: "it is with a wry smile that I read about the controversy regarding cholesterol, fat and heart disease. **Jack Scaff** and I have been saying for a couple of years now that dietary fat and cholesterol are relatively unimportant in heart disease except as related to obesity.

Besides, the recommendations for serum cholesterol levels have been changed every three to four years since I have been out of medical school, so what is a poor soul to believe?

However, recent data indicate that dietary cholesterol and fat may be significant risk factors for cancer. So, while the current controversy rages on, it seems only prudent to continue recommending low dietary fat and cholesterol intake to prevent whatever."

Doug Schramel, marathon-running psychiatrist commented on the incident of the carful of kids shooting a woman jogger . . . "A lot of kids who use a gun have no idea what happens, really happens, after they pull the trigger. At one time, the car was a symbol of freedom. But now, most of us are imprisoned in cars. So if you're a jogger or a bicyclist, subconsciously at least, motorists hate you for your freedom out there. I've had kids throw bottles at me out of a passing car. It usually happens in the afternoon, when all the dopes are out . . . As far as violence toward female joggers goes, these guys may figure, 'If I can't get her one way, I'll get her another!' I also think of Thurber's line: 'I ran over a squirrel in my sex machine.' I'm certain that applies . . . I'm certain that if those guys could have been on a beach with a girl, they never would have done this." (don chapman's column)

Bulletins

Dick and **Irene Blaisdell** are proud parents of daughter **Helen** who was one of the six Hawaii seniors to receive \$1,000 National Merit Scholarships. Helen, senior at Kam School intends to study pre-medicine and her activities include piano soloist with the Honolulu Symphony, first place winner of the state American Legion National Oratorical Contest, student body recording secretary, member of the National Honor Society, school newspaper reporter, and moderator of the Hawaii State Student Conference . . .

Thomas Hall gave in German, the opening address at the 21st Annual Meeting of the Austrian Surgical Society. The meeting was in honor of Dr Wilhelm Denk, founder of the Austrian Institute for Cancer Research. Tom spoke on "The Evolution of the Specialty of Surgical Oncology and the Role of Wilhelm Denk" and later participated in a round table on breast cancer therapy.

"Dr Jack Scaff has been in Bernardsville, N.J. for the funeral of his father, Jack Sr., who is listed in Who's Who in Science for his part in inventing the transistor. You could say father and son are pioneers in their own ways . . ." (don chapman, *Advertiser* columnist)

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Conference Notes

(Submitted by W.F. Haning, III)

Our thanks to W.F. Haning, III Dept of Acute and Emergent Care, Straub Clinic who sent in the following card synopses of medication indications and dosages and his excellent conference notes from Straub Professional Conference on "Pharmaceutical Recommendations in the Arrested Patient," held April 1.

Instructions: Cut, paste/tape/staple onto business-sized cards. Classifications of pharmaceuticals are idiosyncratic. Those noted are ACLS standard, rather than comprehensive; add others peculiar to your medical affect.

GOLDEN RULE 1:

—Any change in pCO_2 of 10 Torr from a normal of 40 is accompanied by a negative pH change of 0.08.

—Thus to calculate, sub values in italics:

(—)pH change = $0.008 \times (pCO_2 \text{ in mm Hg})$

GOLDEN RULE II:

—A pH change of 0.15 is accompanied by a proportionate "base" change of 10 mEq/l, **AFTER THE RESPIRATORY COMPONENT IS CALCULATED** (GOLDEN RULE I).

Thus to calculate, sub value in italics:

Base Excess/Deficit = $67 \times pH \text{ change}$

... with "normal" pH assumed 7.40 ...

GOLDEN RULE III: (have you done I & II?)

Sub value in italics:

(Base Deficit/Excess) $\times \frac{1}{4}$ **WEIGHT** (kg.)

= mEq NaBicar due the patient.

(This assumes ECF is $\frac{1}{4}$ TBW. **Beware** of Bicarb replacement in toxic acidotic states, as A.S.A. poisoning; contraindic'd)

Summary of process of ABG analysis:

—First review adequacy of oxygenation.

—Calculate respiratory component by predicting pH from pCO_2 (G.R. I.)

—Calculate metabolic component by calc'ng Base Excess/Def. from unaccounted pH change (G.R. II).

—Calculate Na Bicarb replacement due the patient (G.R.III), remembering that in toxic acidosis this may depress respiratory drive (can overcome by ventilating).

ANTIARRHYTHMICS:

LIDOCAINE (Xylocaine) HCl: 1 mg./kg. or 75-100 mg. bolus, with 1-4 mg/min IV drip. No systemic effects in low dose, no effects on C.O. Do not exceed 300 mg. bolus. May counter emesis w/ IV antihistamines (not FDA approved. . .).

PROCAINAMIDE (Pronestyl): 2nd-line Rx **p** LIDOCAINE for PVCs: 200 mg- 1 g. IV at no more than 50 mg./min. (thus 4 min. for 200 mg.) *Beware hypotension, heart block, AV conduction disturbances, rarely emesis.*

ATROPINE: 0.5 mg. q. 5 min., not to exceed 2.0 mg. acutely.
Na BICARB: 1 mEq/Kg., then $\frac{1}{2}$ initial dose q. 10 min. Use ABGs if possible.

EPINEPHRINE: 0.5 mg. (5 ml. 1:10,000) q. 5 min., IV or via ET tube.

CALCIUM CHLORIDE: 2.5-5.0 ml. 10% sol'n q. 10 min. (250-500 mg.).

MORPHINE SULPHATE: 3.0-4.5 mg./5-30 min. Up to 10 mg. acceptable if respiratory assistance is at hand (*increases C.O. & decreases rate*)

PRESSORS:

DOPAMINE (Intropin): 2-5 Ug/kg/min., up to 20 Ug/kg/min. Mixed a/b adrenergic, spares renal/splanchnic flow. May cause tachyarrhythmias & PVCs. **DON'T ADD TO BICARB!** Preparation: 200 mg (5 ml.) amp in 500 ml. D5W yields 400 μ g./ml.

PRESSORS:

METARAMINOL (Aramine): a/b adrenergic, releases en-

dogenous catecholamines. Titrate **0.4 mg/ml/min.** & up D/C if dysrhythmic (there are others). **PREPARE** by adding 4 10 (ten) ml. amps. of 100 mg. (400 mg.) to 1 l. of D5W to yield 0.4 mg./ml.

PRESSORS (VASOACTIVE):

LEVARTERENOL (NorEpi): 75% a/25% beta-adrenergic, for peripheral vascular collapse. 16 μ g/ml, 2-3 ml/min—*titrate to BP 90 systolic*. D/C if dysrhythmic. Local extravasation may be ameliorated with Regitine (phentolamine). **PREPARE:** 2 (two) 4-ml. amps of 0.2% LEVARTERENOL in 1 l. D5W to yield 16 μ g/ml.

BETA BLOCKER:

PROPRANOLOL (Inderal): 3rd-line drug, after lidocaine/procaïnamide, for PVC control, more commonly-used long-term. Compromises C.O. and aggravates both CHF & bronchospasm. Give 1 mg. IV/5 min., not to exceed 5 mg. acutely. Frankly, this is a concession to FDA, and you are advised to learn more about BRETYLIUM.

BETA-ADRENERGIC:

ISOPROTERENOL (isuprel): For bradycardia unresponsive to ATROPINE. Inotrope/chronotrope. Beware of digitalis toxicity and hypokalemia. 2-20 μ g/ml/min., *titrating to pulse 60/min.* **PREPARATION** 1 mg. in 500 ml. D5W yields 2 μ g/ml.


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Dosage is 5 mg./kg., up to 10 mg/kg. at 15 min. intervals, not to exceed 30 mg./kg. Hypotension—particularly orthostatic—occurs in 50% of cases.

STEROIDS:

Indication is cardiogenic shock, in which life support may extend for the 4-8 hours required to note effect. Give METHYLPREDNISOLONE (Solu-Medrol) 30 mg/kg. or DEXAMETHASONE (Decadron) 12-12-20 mg q. 6 h., bolus IV. Acutely the contraindications are without concern.

The preceding notes, for appending to business-card-size wallet inserts, are derivatives both of Advanced Cardiac Life Support (American Heart Association) and American College of Emergency Physician recommendations, relating to management of the "Code" patient. They are recommended by the Straub ER staff to all clinicians; DO NOT ASSUME nursing knowledge in preparation; thus the note on Preparation of solution, on each card. This, as all of your and our techniques, is a series which is readily forgotten without dishonor.

—W.F. Haning, III, M.D.

1. **Golden Rules I/II/III:** These are A.C.L.S. Standard, and are empirically-based. The variations which can occur within the rather rigid parameters set out occur in circumstances where extravascular fluid is not adequately represented by—or equilibrating with—intravascular fluid (e.g., ascites, lymphedema, burns, profound blunt trauma, bowel obstruction, etc.). These will modify the "Base Excess/Deficit" particularly, the best example occurring in toxic acidosis. In the last case, an effort to relieve metabolic acidosis will come up against lag in trans-membrane transport of acid metabolites **and** may suppress respiratory drive to a degree requiring mechanical ventilation. In circumstances of extravascular fluid loculation—edema, etc.—the ABG may not reflect tissue base excess/deficit, again due to cell membrane diffusion deficit, and the consequence of base replacement may be unexpectedly rapid **over** responsiveness to therapy, with resultant metabolic alkalosis.

2. **ANTIARRHYTHMICS** (specifically, agents which suppress independent ventricular activity, as PVC's): The sequence of flavor appears to be lidocaine/procainamide/propranolol/bretyllium, albeit this is certainly not a dogma. Some might even call it improper, so variable is the individual circumstance. I have noted wide variance in the choice of second-line antiarrhythmic, dependent on the degree of failure of cardiac output; degree of myocardial irritability (some determinants are felt to include: frequency of PVC's, multifocality of PVC's, location of PVC's in the repolarization phase of EKG); general health of the patient; medications being taken concomitantly (e.g., propranolol, antihypertensive agents with strong orthostatic hypotensive effects,); and specific contraindications (e.g., asthma or COPD in the case of propranolol, hypersensitivity—rare—to "caine" anesthetics in the case of lidocaine/procainamide).

3. **ANTIBRADYARRHYTHMICS:** Atropine, and, failing atropine, isoproterenol (ISUPREL) are the mainstays at my level. Atropine is the agent of choice in bradycardia with either hypotension or frequent autonomous ventricular pacing (PVC's). In the extremely young or old, atropine may be unexpectedly ineffective; thus isoproterenol is noted as alternative. Unlike atropine, the latter is given by drip; its use in the ER is rare, due both to the uncommon circumstance of unresponsiveness to atropine and to the usual rapidity to transfer to ICU/CCU.

4. **PRESSORS:** The issue of greatest controversy in hypotensive states is not merely which pressor to use, but whether to use a pressor at all. Dopamine, while probably the most titrable of pressors, and having as its other advantage **relative** (underscore—this is not absolute) preservation of renal/splanchnic perfusion, resembles metaraminol and levarterenol in that it must be set up as a drip, may cause significant arrhythmias, and may well add to cardiac afterload with

propagation of myocardial injury if injudiciously administered. Though neither ACLS nor available ACEP literature give the matter specific attention, I have noted that the initial approach for most experienced clinicians tends to be the classic one: Epinephrine 0.5-1.0 mg. (cardiologists) and Ephedrine up to 50 mg. (some anesthesiologists), with the other agents reserved for maintenance after initial response. Frankly, pressors frighten me half to death, conforming in so few ways to Osler's dictum that one should be able to reasonably anticipate the effects of a medication on his patient.

5. **ADDENDUM**—Agents not noted in supplement: As Morphine Sulphate is an agent discussed, both for pain and cardiovascular effects, its mention brings up two topics. Alternative analgesics are by far second-best, meperidine frequently causing paradoxical increase in afterload with tachycardia, and butarphanol (STADOL, is a "narcotic antagonist" which will probably be shortly re-classified) causing the same effects with remarkable predictability. However, due to the same emetic response so often noted in giving M.S., the temptation arises to use other agents. Some authors have suggested—without great assertiveness—the giving of antiemetic antihistamines. I've not yet discussed this with our cardiologists; and, in view of the potential for extrasystoles and hypotension, this notion might not meet with great favor. It is worth noting that FDA does approve intravenous usage of diphenhydramine (BENADRYL) and does not disapprove of intravenous usage of promethazine (PHENERGAN), albeit with strong cautions; hydroxyzine (VISTARIL) remains unapproved for intravenous use. We are all aware, I am sure, of the occasional need of the oncologist to use his own judgement on this topic, and perhaps some dialogue would be appropriate.

COMMENTARY: Nothing is so tenuous as the "predictability" of the patient's response to rapid medicinal assault. **However,** When the etiology of the "code" is neither known nor readily-determined, one is always justified in falling back on the above standards, if only owing to the statistical likelihood of respiratory depression or cardiac failure as etiologies in an arrest.

Our "Angels"

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Type manuscript double spaced, including title page, abstract, text, acknowledgments, references, tables, and legends.

Each manuscript component should begin on a new page, in this sequence:

Title

Text

Acknowledgments

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Tables: each table, complete with title and footnotes, on a separate page

Legends for illustrations

Illustrations must be good quality, unmounted glossy prints usually 12.7 by 17.3 cm. (5 by 7 in.) but no larger than 20.3 by 25.4 cm. (8 by 10 in.).

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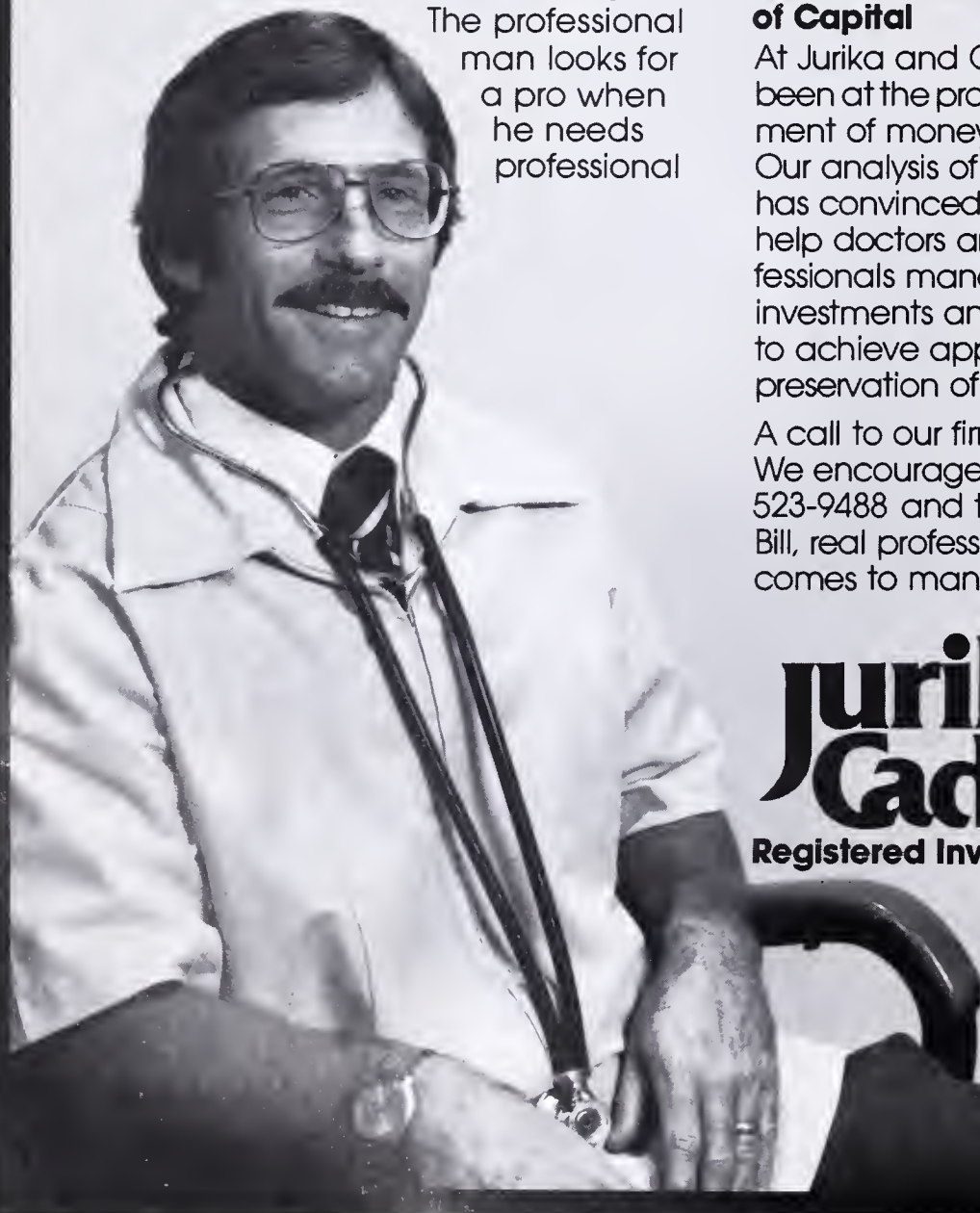
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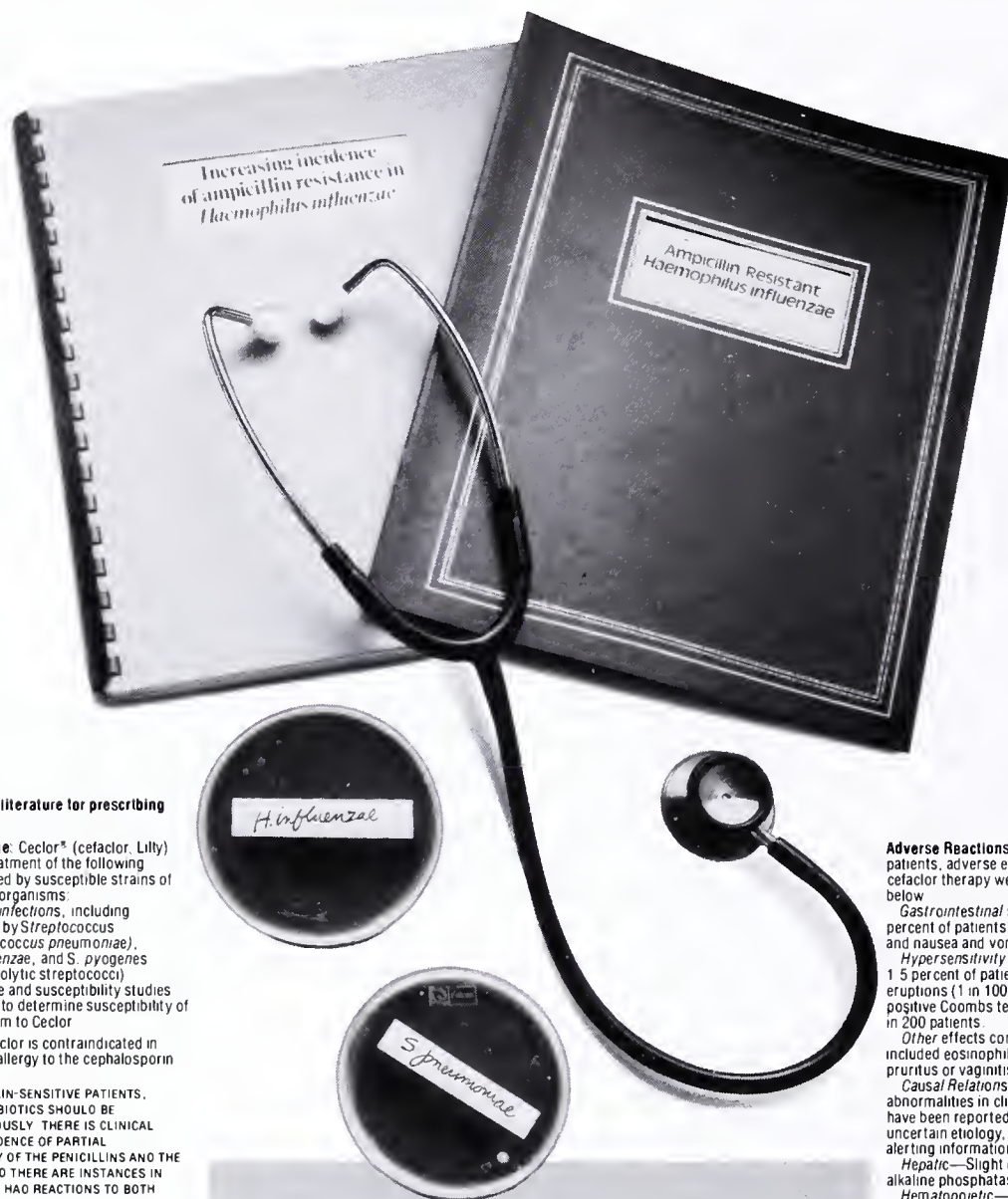


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Remember when lung cancer was a man's disease. Because men had been smoking longer than women. But the women's smoking boom that started in the 1930's and 40's—is paying most cruel dividends today. Yet most people still think lung cancer is a man's disease. Tell your female patients the true story. That lung cancer is now an equal opportunity tragedy. That's what "you've come a long way, baby" is all about.

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An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

000482

Nifedipine: Offering Successful Treatment of Refractory Life-Threatening Coronary Artery Spasm

JEFFREY J. SOL, M.D., DAVID J.G. FERGUSON, M.D.,
and RICHARD REEVE, M.D., *Honolulu*

Coronary artery spasm is an important cause of symptoms in a sub-set of patients with ischemic heart disease. It is frequently associated with life-threatening arrhythmias and is often refractory to conventional therapy. Nifedipine, an experimental coronary artery-dilating drug, has been successful in the treatment of this condition. This drug may be released for general use soon by the FDA.

An excellent response was seen in the first 2 patients in Hawaii to be treated with this drug. There may be other patients locally with coronary artery spasm who would benefit from nifedipine.

Case Reports:

Patient #1: A Hawaiian-Japanese lady first presented in 1975 at the age of 49, complaining of squeezing retrosternal and anterior neck pain. These pains occurred at rest, primarily at night, an average of 4 times a day. There was a history of cigarette smoking, hypercholesterolemia, chemical diabetes mellitus, and a strong family history of ischemic heart disease. Physical examination and EKG were normal. During episodes of pain in the hospital, the patient had no ST-T wave monitor lead changes, but she did develop first degree heart block and Mobitz type-I (Wenckebach) second degree heart block. The chest pain was not relieved by nitroglycerin sublingually. A treadmill stress test showed a negative ST response for myocardial ischemia. A

Bernstein intraesophageal acid drip test and an oral cholecystogram were normal.

Coronary angiography demonstrated a 70% narrowing of the left anterior descending coronary artery (LAD), just distal to the origin of the main diagonal branch. The remainder of the left coronary system showed no significant abnormalities. The right coronary artery (RCA) could not be selectively studied.

The patient was started on P.O. isosorbide dinitrate 10 mg. q 6 h and propranolol 20 mg q 6 h. She responded to this treatment for one month, then started having 4 to 5 episodes of angina at rest. At this time, coronary artery bypass graft surgery was planned, and she underwent repeat coronary angiography to visualize the RCA selectively. The RCA was "dominant" and showed no significant abnormalities. The left coronary artery was again visualized and revealed the same LAD lesion.

Coronary artery surgery was performed and a single saphenous graft to the LAD was inserted. Postoperatively, the patient developed ventricular tachycardia requiring DC shock. The EKG showed an acute apical myocardial infarction. Several days later, she developed episodes of angina pectoris associated with complete heart block and a junctional escape focus at a rate of 40 per minute. A temporary transvenous pacemaker was inserted. The episodes of complete heart block associated with repetitive angina pectoris continued for another 2 weeks, necessitating implantation of a permanent pacemaker.

The patient was discharged on November 8, 1975, again on isosorbide dinitrate 10 mg q 6 h and propranolol 20 mg q 6 h. She initially had

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Accepted for publication February, 1980

frequent episodes of angina. However, after several months, her angina decreased to an average of once or twice a month. She found that she was not helped by the above medications and discontinued them. She was able to return to fairly normal activities for 2 years.

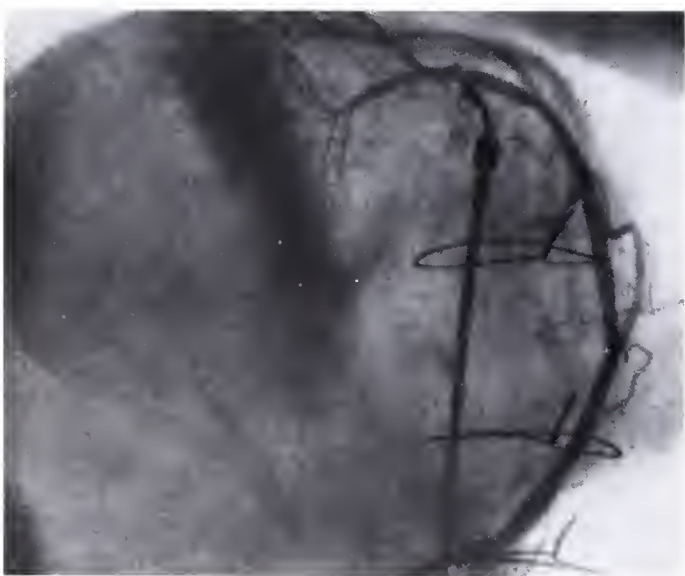
In February, 1979, the patient again developed 3-4 episodes of angina at rest per day. She was started again on long-acting nitrates and propranolol without relief. She was again hospitalized and coronary angiography was repeated. The RCA initially showed no significant obstruction (Fig. 1A). However, after adminis-

FIG. 1A.—Right coronary artery.



tration of ergonovine, it developed total proximal occlusion by spasm, subsequently relieved by nitroglycerin (Fig. 1B). The significant proximal LAD lesion seen in 1975 was no longer seen.

FIG. 1B.—Right coronary artery, post ergonovine.



There was a kinked area more distally in this vessel, associated with a 70% narrowing at the point of attachment of the saphenous vein graft, which was occluded. The left circumflex artery was normal. Ergonovine administration produced no significant spasm in the left coronary system. The left ventriculogram revealed asynergy of the entire apex of the heart, which had not been present in 1975.

Following cardiac catheterization, the patient continued to have 3-5 episodes of angina a day. These episodes were frequently accompanied by multifocal PVCs and brief runs of ventricular tachycardia, but no ST abnormalities. They continued despite the administration of up to 2.5 inches of nitroglycerin ointment q 4 h and discontinuation of propranolol. There was no relief from sublingual isosorbide dinitrate, up to 15 mg q 2 h, and phenoxybenzamine, up to 40 mg a day orally. The malignant ventricular arrhythmias associated with the episodes of angina pectoris were not controlled by therapeutic doses of disopyramide (Norpace), quinidine, or procainamide.

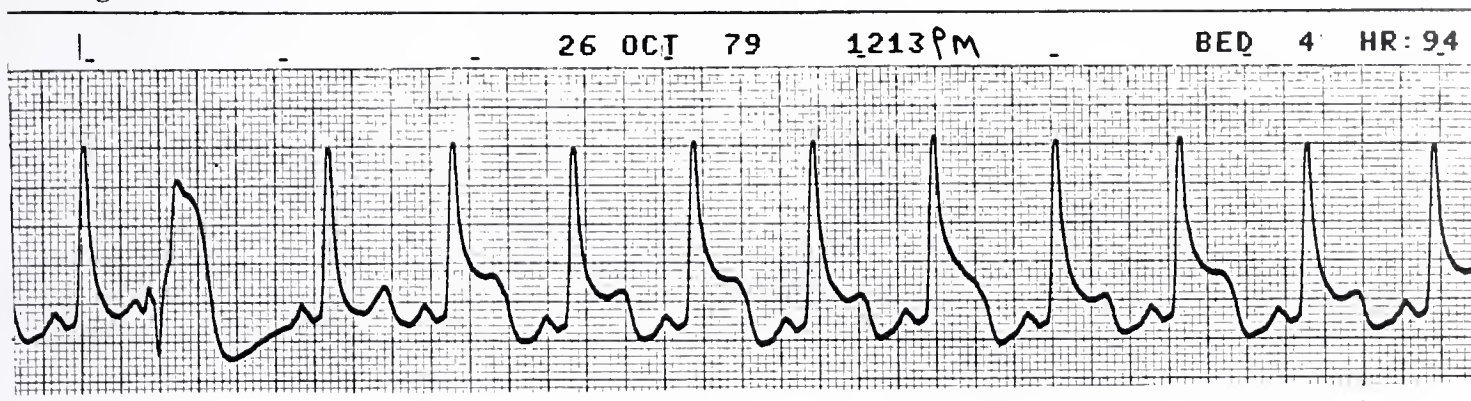
After 3 weeks of juggling the above medications, the patient was started on nifedipine in a dose of 10 mg q 8 h orally, after obtaining informed consent. During a period of 9 months, she has not had a single episode of angina pectoris. Initially, there was asymptomatic hypotension in the range of 80/50 mm Hg requiring reduction of the large doses of isosorbide dinitrate. There have been no other side effects. The patient is now on isosorbide dinitrate 10 mg p.o. 4 times a day in addition to nifedipine. She is on no anti-arrhythmic medications.

Patient #2: A 46-year-old Hawaiian lady was hospitalized on October 22, 1979 because of an episode of chest pain. She had a long history of hypertension and LVH. She had a right CVA 3 weeks prior to hospitalization. Cardiac examination was normal. EKG showed LVH. There was no evidence by EKG or enzymes of an acute myocardial infarction. Recurrent episodes of variant angina pectoris developed in the hospital beginning on October 24. These episodes were associated with ST elevation on the EKG monitor leads (Fig. 2) and also with malignant ventricular irritability. There was one episode of ventricular tachycardia. These episodes of angina pectoris continued despite the administration of 2 inches of nitroglycerin ointment q 6 h and isosorbide dinitrate sublingually 5 mg four times a day. There were 4 episodes on October 26.

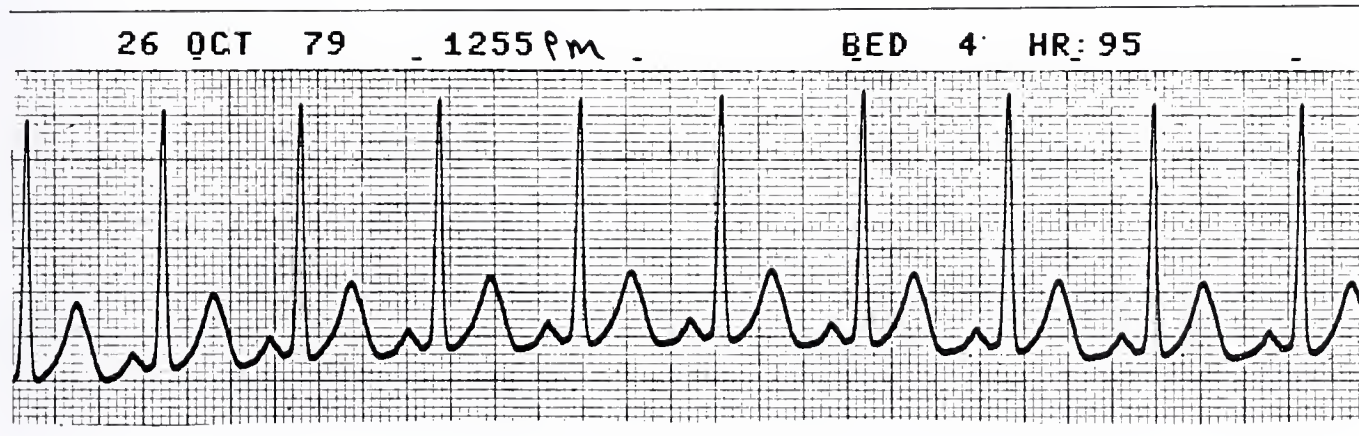
The last episode of variant angina occurred a half hour before the administration of the first capsule of nifedipine. After we obtained informed consent, nifedipine was begun at the minimum dosage level of 10 mg orally q 8 h on October 26, 1979. There have been no further episodes of angina pectoris since that time. The only side effect was a mild headache which lasted 48 hours and has not bothered the patient since. There has been no significant hypotension.

Coronary angiography was performed on October 31, 1979. There was a right "dominant" coronary circulation. The only significant lesions were in the LAD. There was a 60% narrowing of the proximal LAD and an 80% proximal stenosis of its first diagonal branch.

The patient has been continued on nifedipine 10 mg q 8 h orally and nitroglycerin



After Pain



ointment 1.5 inches 4 times a day. She has had no further episodes of angina pectoris or other cardiac problems. However, she was hospitalized again in November, 1979, for an interstitial pneumonitis, probably of viral origin. She was hospitalized in December, 1979 for another CVA.

Discussion

Spectrum of Coronary Artery Spasm. The syndrome of Prinzmetal's, or variant, angina pectoris is typically associated with coronary artery spasm. This syndrome consists of angina pectoris occurring spontaneously at rest, not on exertion, and associated with ST elevation, not depression, on the EKG. Prinzmetal's original patients all had severe obstruction of a single coronary artery. Coronary spasm was thought to occur at the site of preexistent narrowing.¹ A significant percentage of patients with typical variant angina have since been shown to have normal coronary arteries. Also, as in patient #1, the particular EKG lead being monitored may not show ST elevation. There may be ST depression or no change at all.² Cardiac arrhythmias may also occur.

Coronary artery spasm has also been implicated as a mechanism in acute myocardial infarction, sudden death and unstable angina pectoris.³

In both of the patients presented, the clue to the existence of spasm rather than fixed obstruction was the history of angina pectoris occurring primarily at rest. A lesser clue was the tendency of arrhythmias to occur with the angina. The

coronary angiograms by themselves suggested "garden variety" coronary artery disease.

In-Patient No. 1, the LAD lesion seen on the original 2 coronary angiograms may not have been the cause of the patient's symptoms, since the spasm produced by ergonovine occurred in the anatomically near-normal right coronary artery. RCA disease would explain the first degree AV block and Wenckebach rhythms demonstrated during the episodes of angina pectoris on the initial hospital admission in 1975 better than LAD disease. These rhythms suggest AV nodal ischemia. The AV node is supplied by the right coronary artery in patients with a right dominant circulation, and not by the LAD. Patient No. 2 superficially resembles Prinzmetal's original case descriptions of single vessel disease with superimposed spasm. The spasm in this case was deduced from the occurrence of ST elevation, coincident with episodes of rest angina. However, the spasm was not documented to occur in the area of the "fixed" obstructions in the distribution of the LAD coronary artery. In fact, the monitor lead which demonstrated the ST elevations was an "inferior" lead (lead 2), raising the possibility of spasm of the anatomically normal RCA.

Treatment of Coronary Artery Spasm. The conventional treatment of coronary artery spasm consists of the use of long-acting nitrates, such as isosorbide dinitrate. However, this treatment is effective in less than 50% of patients.⁴ Propranolol is not generally recommended for coronary artery spasm. In fact, it may worsen the

symptoms. Alpha adrenergic blocking agents such as phenoxybenzamine have been tried with little success.

The role of coronary artery bypass graft surgical therapy is controversial. Certainly it has no role in the patient without severe "fixed" obstruction. Even when such obstruction is present, the operative mortality and results appear to be worse than in patients with conventional angina.^{5,6} Patient No. 1's experience with surgery fits with this observation.

Nifedipine, however, has been shown to be effective in the treatment of coronary artery spasm.

Nifedipine has been approved for general use in 32 countries, including Germany, Japan and England. Many studies have documented its effectiveness in the treatment of coronary artery spasm. A recent study of 100 patients treated in the United States reported that 58% had no further episodes of angina pectoris after institution of nifedipine. 78% of patients had at least a 75% reduction in the frequency of episodes of coronary artery spasm.⁷

Nifedipine is a calcium-blocking agent. It prevents the calcium-mediated contraction of coronary artery smooth muscle, thereby reversing coronary artery spasm. Besides dilating

coronary arteries, it also dilates cutaneous and skeletal muscle arteries. It has a weaker dilating effect on cerebral, mesenteric and renal arteries.

It is given orally, in doses ranging from 10 mg t.i.d. to 30 mg q.i.d. Its peak action is 1-2 hours after administration and its half life is 4-5 hours.

Side effects have been remarkably few and benign. Hypotension has not been a major problem. Headaches, nausea, paresthesias and dizziness—due to its vasodilating effect—have occurred. However, only in 5% of patients have side effects been severe enough to cause discontinuance of the medication.⁸

The 2 patients presented here have had an excellent response to the drug. Both have been angina-free since nifedipine was begun. Both have been maintained on the minimum dose of 10 mg t.i.d. Patient No. 1 has been treated for 9 months, and patient No. 2 for 3 months.

Physicians in Hawaii who have patients for whom nifedipine is indicated can obtain the drug by contacting Pfizer Pharmaceuticals, 235 East 42nd Street, New York, New York 10017.

Acknowledgements

We would like to gratefully acknowledge the literary and secretarial assistance of Mrs. Judith A. Mori, CMT.

REFERENCES

1. Prinzmetal M, et al.: Variant form of angina pectoris. *JAMA* 174: 1974, 1960.
2. Maseri, A, et al.: "Variant" angina: one aspect of a continuous spectrum of vasospastic myocardial ischemia. *Am J Cardiol* 42:1019, 1978.
3. Helfant H: Coronary spasm. *Am J Cardiol* 44:839, 1979.
4. Heupler F A, Proudfit W L: Nifedipine therapy for refractory coronary arterial spasm. *Am J Cardiol* 44:801, 1979.
5. Wiener L, et al.: Spectrum of coronary arterial spasm. Clinical, angiographic, and Myocardial metabolic experience in 29 cases. *Am J Cardiol* 38:945, 1976.
6. Endo M, et al.: Prinzmetal's Variant Form of Angina Pectoris, Re-evaluation of Mechanisms. *Circ* 52:33, 1975.
7. Antman E, et al.: Nifedipine therapy for coronary spasm: collective clinical experience in the United States. *Circ* 4:76, 1979.
8. Lown B: The future clinical role of nifedipine. *Am J Cardiol* 44:839, 1979.



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The Low Incidence of Cephalothin Resistant Enterobacteriaceae at Straub Hospital

FRANCIS D. PIEN, M.D., *Honolulu*

● During a 2-month study period, 156 Enterobacteriaceae were tested by the agar overlay disk method for resistance to cephalothin. Resistant isolates numbered 22 (14% of total Enterobacteriaceae); of these, 19 were sensitive to cefamandole and 14 to cefoxitin. It is suggested that these costly cephalosporins be reserved for special clinical situations and not be used routinely in surgical prophylaxis or for bacterial infections which demonstrate susceptibility to the older cephalosporins.

We reported, during a study period in 1977, that a fourth of our hospitalized patients received antibiotic treatment, with approximately half the antibiotics used prophylactically.¹ The major expense of antibiotics was for cephalosporins, because of their high cost and frequency of prophylactic use. Recently, 2 new parenteral cephalosporins (cefamandole and cefoxitin) have been introduced.²⁻⁴ These new antibiotics are considerably more expensive (\$50-150 for 8 grams/day) than the older cephalosporins, but are promoted for widespread use in both prophylaxis and therapy because of a broader antibiotic spectrum against Gram-negative bacteria. We have, therefore, determined during a 2-month study period the frequency of Enterobacteriaceae isolated at our hospital resistant to cephalothin, but sensitive to cefamandole or cefoxitin.

Materials and Methods

From June 1 to July 31, 1979, all Gram-negative rods obtained from hospitalized patients were identified by the API-20 method (Analytab Laboratories, Plainview, NY). Disk susceptibilities to cephalothin were performed on these isolates by the agar overlay disk

method.⁵ Isolates resistant to cephalothin were then tested by disk method against cefamandole (10 mcg) and cefoxitin (10 mcg). Excluded were isolates of *Pseudomonas aeruginosa*, which are uniformly resistant to both cefamandole and cefoxitin.³ In addition, *Bacteroides fragilis* was only isolated 5 times during the study period, and no anaerobic sensitivities were done.

Results

During the study period, 156 Enterobacteriaceae isolates were received from hospital patients. These included 81 isolates of *Escherichia coli*, 40 *Klebsiella pneumoniae*, 10 *Proteus mirabilis*, 8 *Enterobacter* sp., and 17 miscellaneous bacteria (*Serratia*, *Citrobacter*, *Providencia*, indole-positive *Proteus*, etc.).

There were 22 Gram-negative rods which were resistant to cephalothin (Table 1). This represented 14% of the isolated Enterobacteriaceae. Of these 156 total isolates, 19 (13%) were susceptible to cefamandole and 14 (9%) to cefoxitin. This susceptibility included all cephalothin-resistant *E. coli*, two *Serratia* isolates, and most *Morganella*. Cefamandole was more effective than cefoxitin against *Enterobacter* and miscellaneous bacteria.

Discussion

This study demonstrates that cephalothin resistance was relatively infrequent among the Enterobacteriaceae that were recovered from our hospital patients. This can be partially explained because *Serratia*, *Enterobacter*, indole-positive *Proteus*, *Providencia* and *Citrobacter* were uncommon isolates in our community practice. Also more common Gram-negative bacteria have not developed widespread resistance to cephalothin in spite of frequent long-term usage. This is similar to the report by Moellering who found that bacterial resistance to cephalothin had not

Straub Clinic and Hospital; and University of Hawaii
John A. Burns School of Medicine

Accepted for publication February, 1980.

TABLE 1.—Sensitivities of Cephalothin-Resistant Bacteria

BACTERIA RESISTANT TO CEPHALOTHIN	NUMBER OF ISOLATES	NUMBER OF BACTERIA SENSITIVE TO:	
		CEFAMANDOLE	CEFOXITIN
<i>Escherichia coli</i>	6	6	6
<i>Morganella morganii</i>	6	4	5
<i>Enterobacter</i> sp. (<i>E. cloacae</i> , <i>E. aerogenes</i> <i>E. sakazakii</i>)	4	3	0
<i>Serratia marcescens</i>	2	2	2
Miscellaneous bacteria (<i>Citobacter</i> , <i>Providencia</i> , etc.)	4	4	1
Total	22	19	14

increased at the Massachusetts General Hospital from 1971-76.²

Because of the relatively small number of Gram-negative isolates which would benefit from the use of the newly introduced cephalosporins, we have limited their use in our hospital to special situations. Previous *in vitro* broth and agar dilution susceptibility studies have demonstrated that cefamandole is active against most *Hemophilis influenzae* and indole-positive *Proteus* sp, as well as many *Enterobacter* sp. and some *Serratia* sp.^{2,3} Cefoxitin is active against the majority of *Bacteroides fragilis* isolates, and there-

fore useful in mixed abdominal or pelvic abscesses.⁴ We, therefore, recommend that these costly, new cephalosporins not be used for routine surgical prophylaxis against *Staphylococci* (cardiac or orthopedic surgery) or against bacteria which are sensitive to the older cephalosporins. In our Straub Hospital experience, both cephalothin (Keflin) and cephapirin (Cefadyl) have been interchangeable, and we substitute in our hospital for the less expensive drug. We feel that cefamandole and cefoxitin should be restricted to situations in which their unique properties would be most useful.

REFERENCES

1. Pien FD, Lau WKK, Sur N: Antibiotic use in a small community hospital. *West J Med* 130:498-502, 1979.
2. Moellering RC Jr: Cefamandole—a new member of the cephalosporin family. *J Infect Dis* 137 (suppl): S2-S9, 1978.
3. Eickhoff TC, Ehret JM: In vitro comparison of cefoxitin, cefamandole, cephalixin, and cephalothin. *Antimicrob Agents Chemother* 9:994-999, 1976.
4. Darland G, Birnbaum J: Cefoxitin resistance to beta-lactamase: a major factor for susceptibility of *Bacteroides fragilis* to the antibiotic. *Antimicrob Agents Chemother* 9:452-457, 1976.
5. Barry AL, Garcia F, Thrupp LD: An improved single disk method for testing the antibiotic susceptibility of rapidly growing pathogens. *Am J Clin Pathol* 53:149-158, 1970.

HAWAII MEDICAL ASSOCIATION 124TH ANNUAL SCIENTIFIC MEETING October 13-17, 1980 CALENDAR OF EVENTS

September 5, 6 & 7	Annual Skin Diving Tournament	October 13, Mon.	Visit Scientific and Technical Exhibits, Marlin Room. 5 p.m. to 7 p.m. During the cocktail reception.
September 21, Sun.	Annual Deep Sea Fishing	October 13, Mon.	Computerized Electrocardiography—"The Physician's Assistant," 7 p.m. to 8 p.m., Mahimahi Room
September 24, Wed.	Annual Doubles Table Tennis	October 13-15 Mon., Tues., Wed.	Visit Scientific and Technical Exhibits, Marlin Room. 7 a.m. to 12 noon
October 8, Wed.	Annual Singles Table Tennis	October 14, Tues.	"Joining a Group or Partnership" Seminar, 1 p.m. to 5 p.m. Call BME, 536-9691 for registration/fee information
October 11, Sat.	Annual Singles Tennis Tournament	October 15, Wed.	HMA House of Delegates Reconvenes, 1:30 p.m., Ahi Room.
October 12, Sun.	Annual Doubles Tennis Tournament	October 16, Thurs.	Annual Golf Tournament, 10:00 a.m., Navy-Marine Golf Course
October 12, Sun.	Registration Desk opens, 1 p.m., Pacific Beach Hotel, Aikane Room	October 16, Thurs.	Annual Sportsmen's Night Party, 6:30 p.m., Cathay Room, Hilton Hawaiian Village, Golden Dragon Restaurant.
October 12, Sun.	"Managing The Business Side" Seminar, 8:30-5:30 p.m. (lunch included). Call BME, 536-9691 for registration/fee information.	October 17, Fri.	"Closing A Medical Practice" Seminar, 1 p.m. to 5 p.m. Call BME, 536-9691 for registration/fee information.
October 13-17 Mon. thru Fri.	Continental Breakfast for all registrants and participants, from 7-8 a.m., Aikane and Marlin Room.	October 17, Fri.	HMA Annual Banquet, cocktails at 6 p.m., dinner at 7 p.m., Pacific Beach Oceanarium Grand Ballroom
October 13-17 Mon. thru Fri.	HMA Postgraduate Courses, 8:00-12:30 p.m. (check your program).		
October 13, Mon.	HMA House of Delegates Opening Session and Reference Committee meetings. 1:30 p.m., Ahi Room.		
October 13, Mon.	HMA Hosted Cocktail Reception for registrants, exhibitors and guests, 5-7 p.m., Aikane and Marlin Room.		

For further information, call the HMA Office, 536-7702.



"It Ain't Your Sugar!"

In 1920, my father, then a Major in the Medical Corps, U.S.A., went into the old Beaver Saloon on lower Fort Street—later the Merchant's Grill—to kill time while he waited for an Army transport to dock; he had to meet an incoming brass hat.

He asked the barman for a cup of coffee, and one was slid to him along the bar with a spoon standing up in it. There was a bowl of sugar, but no spoon in it, and he asked for a clean spoon. "Ya got a spoon," growled the barman. "I know," said my father, "but it's in the coffee, and I don't want to get coffee in the sugar." "Whadda you care?" inquired the barman. "It ain't *your* sugar."

The barman's attitude toward the sugar, and the disregard he thought his customers ought to have for it, neatly exemplifies the attitude of many in the Federal and State bureaucracy toward tax revenues and the spending of them.

"Whadda we care?" one can almost hear them saying. "It ain't *our* sugar!"

What we could all benefit by, in government, is a few legislators and a few department functionaries who are able to consider that these funds *are* "their sugar," and ought to be husbanded a bit more carefully. Every time I read about some department hastening to spend some remaining funds, lest they have their next allotment reduced, I think of that barman, and his indifference to the spoiling of the sugar.

HLAJR

Unit Rule: Reprise

The thorny issue arose again in discussions of physician recruitment during the HMA's recent Leadership Conference. Under the present "unit rule," medical society membership at county, state, and national levels remains an all-or-none proposition. One cannot elect membership in the county society or HMA without joining the AMA as well, and vice versa.

Proponents of the status quo maintain that without unit rule the AMA might lose membership, which in turn would weaken state representation on the national level; they insist that the strength of our national organization becomes increasingly critical in these perilous times. Opponents, however, believe that membership options would stimulate local recruitment of nonmember physicians who now express philosophical or financial opposition to mandatory AMA membership, while not necessarily reducing the ranks of members currently supporting the AMA; these critics insist that charity begins at home, and that representation of a majority of physicians by our local societies becomes increasingly critical in these perilous times.

There are now only five other states with unit rule; in a consumerist era, perhaps the concept has proven anachronistic. Certainly the issue deserves periodic reconsideration. Experiences of states which have recently abolished unit rule need careful examination, although results may not have relevance for Hawaii. Then a debate should be held. When all the facts and opinions have been heard, a new referendum ought to be conducted, to which decision our House of Delegates should be bound.

The controversy erupts every few years, as perhaps it should. But this *bete noire* won't just go away; it can best be confronted boldly, in the light of reason.

JMC

Cans of Worms

If at first you don't succeed, spend more money. Government-sponsored Health Maintenance Organizations (HMOs) have been failing so miserably (as many as seven a year due to mismanagement alone), that the Department of Health and Human Services (HHS, formerly HEW) finds itself now entering the management training business. When two \$100,000 a year executives of one Detroit HMO recently blundered away \$1-million of tax money in a single year, HHS began developing a training course to prevent further grotesque deficiencies in management of Federally-sponsored HMOs.

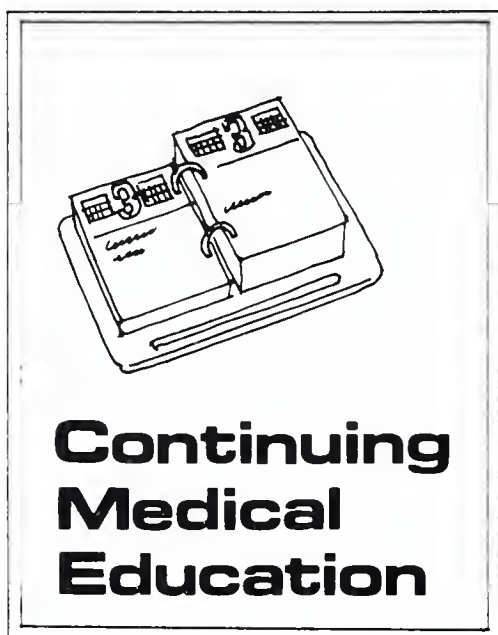
It seems that the problem of high-salaried incompetents might better be remedied by examining the hiring process, rather than establishing remedial training schools. The Federal rush to subsidize exclusively this facet of medical care has produced so many examples of profligacy, that it becomes ever more apparent that government has absolutely no business being in business.

One good regulation deserves another. When the FDA was instructed by Congress to assure that drugs were safe, it was assumed that the definition of "drug" was common knowledge. A few eyebrows went up ten years ago when the reg-

ulators chose to classify soft contact lenses as "new drugs." After the bureaucrats pushed increasing numbers of non-drugs such as catheters, pacemakers, and prostheses into the "investigational drugs" category, Congress finally listed "devices" under the law, as one means of correcting the absurdity.

To gain further control over medical devices, HHS now contemplates regulating the users themselves. Take the case of intraocular lenses, currently subjects of the largest and most expensive clinical study in history. Since the devices themselves seem innocuous, regulators now question whether eye surgeons implanting them are equally safe; the HHS recently considered investigating surgical training, and perhaps accrediting implant surgeons! From drugs to devices to surgical certification—where will it end? And what has any of this to do with securing "Life, Liberty, and the Pursuit of Happiness?"

JMC



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.


- D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
- E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
- F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
- G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
- H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.

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- B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
- C. Pediatric Infections Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
- D. Neonatal Grand Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
- 6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
- 7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
- 8. Department of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
- 9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
- 10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.

- 11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

- 1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
- 2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1.
 - A. **8/18/80**—Anals of Emerg. Med. (June 1980) 9-11 a.m. Abstracts in ER Med. (May 1980)
 - B. **9/22/80**—Anals of Emerg. Med. (July 1980) 10-12 noon-Abstracts in ER Med (June 1980)
 - C. **10/20/80**—Anals of Emerg. Med. (Aug 1980) 10-12 noon-Abstracts in ER Med (July 1980)
 - D. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 - E. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

- 1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

Hickam Clinic

- 1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
- 2. Didactic—our staff, Second Thursday, 11:00 a.m.
- 3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
- 4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

- 1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
- 2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
- 3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
- 4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
- 5. C.P.C., Second Friday, 12:30-1:30 p.m.
- 6. Visiting Professor's Program

Kaiser Hospital

- 1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
 - 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
 - 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
 - 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
 - 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

- 1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
- 2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
- 3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
- 4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
- 5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 - First—Didactic Presentation
 - Second—Perinatal-Neonatal Topics
 - Third—Obstetrics Topics
 - Fourth—Gyn Topics
- 6. Tumor Bd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

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Kuakini Medical Center

1. Visiting Professor Programs
2. Department of Ophthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
3. G. I. Conference, Third Tuesday, 8:00-9:00 a.m.
4. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
6. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, Third Thursday, 1:00-2:00 p.m.
8. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
9. Surgical Mortality & Morbidity Conference, Fifth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.

5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

- | | |
|----------------------------------|--|
| Sept. 15,
19, 1980 | Updating Progress in Infertility, American Fertility Society and Serono Symposia, Held at Maui. |
| Sept. 16,
23, 1980 | Gastrointestinal Radiology. San Diego Radiology Res. & Educ Found., Box 2305, LaJolla, CA 92038. Cosponsor-Am Coll of Radiology. Held at Maui Surf Htl. 4 days-30 hrs. Cat. 1. |
| Sept. 16-
18, 23, 25,
1980 | Advanced Cardiac Life Support Provider Course. HI Heart Association, contact: Skip Kirkwood, Program Director (808) 531-0174. 1301 Punchbowl St., Suite 203. 16 hrs. Cat. 1. Fee \$150.00. |
| Oct. 3,
4, 1980 | Medicine in the 80's-State of the Art. 7:00-10:00 p.m.-10/3 9:00 a.m.-8:00 p.m. 10/4. Held at Prince Kuhio Htl, Waikiki. Spons. HMA-co-sponsor Unity Church of HI & UH Schl. of Nursing. Contact: John Watson, M.D. (808) 948-8585. 7 hrs. Cat. 1. |
| Oct. 5-
11, 1980 | Recent Advances in Neurology-Spons: The Honolulu Medical Group Research & Education Found. & International Cntr. for Health Ed-Kauai. 25 hrs. Cat. 1. Contact: Robt. M. Schmidt, M.D.-Internatl. Cntr. for Health Ed., P. O. Box 3109 Lihue, Kauai, HI 96766, (808) 245-2121. Held at Kauai. |
| Oct. 7-
11, 1980 | Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. 1. Contact: Mary J. Ryals, P.O. Box 2305, LaJolla, CA 92038 (714) 459-9787. |
| Oct. 11,
19, 1980 | Fifth Annual International Body Imaging Conf., Dept. of Radiology at West Park Hsp, Canoga Park, CA 91304. Held at Kauai Surf Htl. Kauai, HI. |
| Oct. 13-
17, 1980 | 124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8- |

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With savings interest rates changing so often, it seems like everyone in the world has plans for your money, right? But how do you decide which savings plan? How much? How long? Here's a clear-cut shopping guide to our most popular savings plans. If you have any more questions, come talk to one of our Customer Consultants.

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Unconfusion #2 SAVINGS PLUSBOOK

\$500 minimum deposit. \$100 minimum additions at any time. Maturity periods from 1 to 3 years. 6%-6½% interest per annum.

Advantage: If you're a small investor making regular deposits, this plan allows you to earn higher interest than a conventional savings account.

Disadvantage: Substantial penalty for early withdrawal.

Unconfusion #3 BANK BILL (6-Month Money Market Certificate)

\$10,000 minimum deposit. 26-week maturity. Interest rate determined by the weekly Treasury Bill rate and fixed for term of deposit.

Advantage: Your opportunity to earn a high return.

Disadvantage: Larger minimum deposit. Because of fluctuating Treasury Bill rates, you may not be able to reinvest your money at the same high rate at the end of the 26-week period. Substantial penalty for early withdrawal.

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\$100 minimum deposit. 30-month maturity. Interest rate determined every two weeks fixed for term of deposit.

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Disadvantage: You must commit your money for longer term. Substantial penalty for early withdrawal.

Unconfusion #5 BANK BONDS

\$637.66 minimum deposit. Maturity periods from 1 to 6 years. 6%-7½% interest per annum.

Advantage: A guaranteed pay-off for those of you who need a fixed amount at the end of a fixed period. For example, buy a bond today for \$3,188.29 and in 6 years collect \$5,000!

Disadvantage: Substantial penalty for early withdrawal.

Unconfusion #6 TIME CERTIFICATES OF DEPOSIT

\$500 minimum deposit. Maturity periods from 30 days to 8 years. 5%-7¾% interest per annum. Higher rates available for IRA and Keogh deposits and deposits of \$100,000 or more.

Advantage: A chance to earn higher interest if you're willing to commit your money for a fixed period of time. Wide flexibility of maturity periods.

Disadvantage: Substantial penalty for early withdrawal.



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12noon. Contact: HMA office (808)536-7702 for further info.

- Oct. 18-25, 1980 Western Orthopedic Assoc. Held at Hilton Hawaiian Village. Contact: H. Jacqueline Martin, Exec. Sec., 1970 Broadway, Oakland, CA 94612.
- Oct. 25, Nov. 1, 1980 Operative Arthroscopy, UCLA. Los Angeles, CA 90024, co-sponsor, J. A. Burns Schl. of Med, (808) 947-8573. Held at Hyatt Maui, Maui, HI.
- Oct. 30, 1980 Leprology—Panel from Carville, LA. Thursday, 4-5:00 p.m. Queens Univ. Tower, Rm. 618. Co-sponsor Dept. of Hlth. HI & J. A. Burns School of Medicine, and HMA. Contact (808) 947-8573.
- Nov. 3-5, 1980 Recertification Course for ACLS Providers-HI Heart Assoc. CPR Cntr. of HI, 1301 Punchbowl St., S 203, Honolulu. 8 hrs. Cat. I; Fee \$150. Contact: Skip Kirkwood, Prog. Dir. (808) 531-0174.
- Nov. 23, 30, 1980 New Directions in Psychiatry, U of Wash., John N. Lein, M.D., Div. of CME, Box SC-50, Seattle, Wash, 98195. Co-Spons. J. A. Burns Schl. of Med. Held at Ilikai Htl., Honolulu.
- Dec. 11-14, 1980 Am. Med. Joggers Assoc. Contact: Hugh S. Ames, Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.
- Dec. 14-20, 1980 Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International

Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

We would like to devote most of this month's column to a report from the Education Committee on fail-safe methods to insure proper recording of your CME credits.

The computerized CME system, based at AAFP headquarters in Kansas City, is still in a transitional period with a few "bugs" persisting here and there.

The key to success for correct computerization of you "P" credits is to mail in your yellow cards (or ask the course director to do so and be sure he *does*) for each course attended.

The course title on your yellow card *must* read exactly the same as submitted by the course sponsor. The secret here is to use the *Generic* or general course title—NOT the specific subject discussed.

Examples:

- 1) Hawaii Chapter (HAFP) Bimonthly Dinner Meeting—(NOT "Stress Identification and Management")
Give date(s), Location: Honolulu, Sponsor: HAFP
- 2) Queen's Medical Center Medical Conference—NOT "Hemophilia Update"
Give date(s), Location: Queen's Medical Center Honolulu, Sponsor: Queen's-U.H.
- 3) Saturday Staff Educational Conferences—NOT "Ampicillin Use and Abuse"
Give date(s), Location: Kaiser Foundation Hospital, Sponsor: Kaiser Foundation Hospital

Faithful compliance will yield you (and your Exec. Sec.) at year's end a beautiful, accurate computer printout. Please keep your own list also, so you can check up on the computer.

Due to past mistakes by course sponsors, some programs, even though approved for "P" credit, were not properly entered in the computer. These errors result in "N" on your printout, however the Hawaii Executive Council can change them to "P." At present

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steps are being taken to prevent such errors in the future.

Remember—computer out-put is only as good as computer in-put.

We now have CME coordinators at most Oahu hospitals, please contact them with any questions:

Queen's—Pat Dietrich; St. Francis—Tom Cahill; Kaiser—Don Farrell; Castle—Glenn Stahl; Children's-Kapiolani—Doris Jasinski; Tripler—Bob Todd; Wahiawa General—Norberto Baysa. We hope to have coordinators soon at Neighbor Isle hospitals also.

In other news, the Executive Council voted at its last meeting to mail the newsletter (published in the HMA Journal) to all members on a bimonthly basis, since a number of our members do not receive the Journal.

President **Pat Dietrich** appointed **Arch Wigle** and **Bob Todd** to serve as councillors till the annual meeting in January, when elections will be held. They replace **Don Newman** and **Joe Fitzharris**, who have moved out of state.

The next **Annual Meeting** will be held on January 24, 1981 and a one day seminar is being planned. So mark your calendars now.

Our next **Dinner Meeting** will take place on September 6 at the home of Tom and Jinny Cahill. On the program will be **Roland Tam** with "Office ENT" and **Nate Wong** with an account of his experiences as a crew member on the Hokule'a.

Lately Family Practice has received some media attention. **Jim Tsuji** was a guest on **Joe Rose's** "Focus Hawaii" August 2nd, and **Don Farrell** was interviewed for Channel Two News in connection with the winding down of the Family Practice Residency program at Kaiser Hospital.

See you at the AAFP Annual Meeting in New Orleans in October!

Announcement

The HMA Nominating Committee met to receive nominations for officers and other elected positions of the Hawaii Medical Association that are to be elected by the HMA House of Delegates at its Annual Meeting October 13-17, 1980. The Nominating Committee will submit to the House of Delegates the following slate of nominees:

President-Elect Ann B. Catts, M.D.
(1 to be elected) Arch T. Wigle, M.D.

Secretary Leonard Howard, M.D.
(1 to be elected) K.Y. Lum, M.D.

Alt. Delegate to AMA ... William Iaconetti, M.D.
(1 to be elected) Richard O. Lundborg, M.D.

Councillor from Kauai John Newman, M.D.
(1 to be elected) Mark A. Wentworth, M.D.

Councillors from Honolulu. Nadine C. Bruce, M.D.
(4 to be elected) Thomas G. Cahill, M.D.

Bernard W. D. Fong, M.D.

Doris R. Jasinski, M.D.

Philip I. McNamee, M.D.

Kenneth Pruett, M.D.

E. Lee Simmons, M.D.

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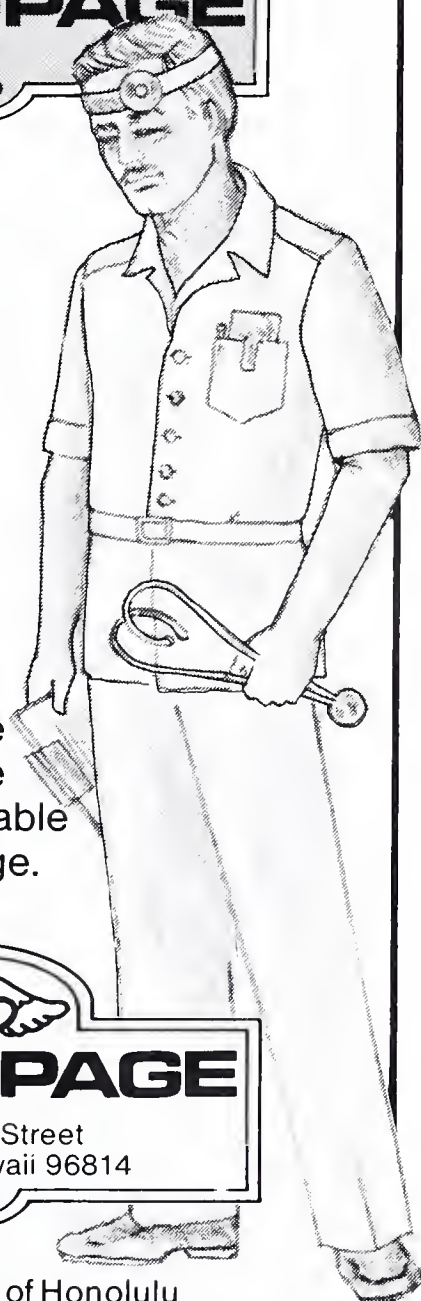
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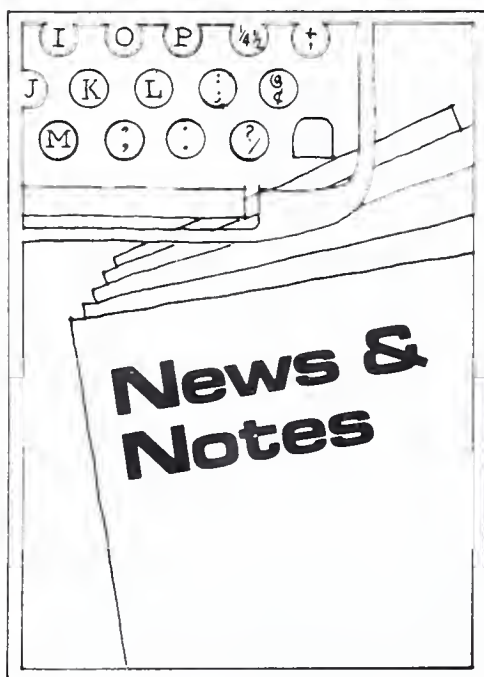
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HENRY N. YOKOYAMA, M.D.

Life In These Parts

Marathoner **John Wagner** was sitting in a London airport lounge reading *The Telegraph* when he noted a story about Hawaii . . . A journalist, a Nigel Buxton, apparently spent a few days in a Lihue hospital, and wrote: "Some of the nurses were Filipino girls with dark hair and accents as pretty as their faces. The touch of their fingers was exotic butterflies on the skin." (don chapman, *Advertiser* columnist)

Michael Catalano of the Arthritis Center at the John Burns School of Medicine warned that an arthritis medicine made in Hong Kong called "Chuifong Toukuwan" is a fraud and a rip-off and has active ingredients with serious side effects.

In May 1979, the State established the program of mandatory substitution with generic drugs for Medicaid patients. Earl Motooka, state medical welfare specialist happily says the state saved \$713,000 or 11% of the \$6.5 million Medicaid drug bill and estimates that for the coming year the state will save \$1.4 million of the total \$7.2 million drug budget. Physicians, pharmacists, and welfare recipients, however, are apparently unhappy with the restrictive formulary . . .

Two mainland hospital chains are vying for the right to build the first private, for-profit psychiatric hospital in Hawaii. Charter Medical Corp of Georgia has more than two dozen hospitals across the nation and Community Psychiatric Centers of California operates 15 private mental health facilities in the U.S. and in London. CPC wants to build a 132 bed facility on a 4.55-acre site adjacent to Kaiser's Punawai Clinic in Waipahu, while Charter plans an 80-bed facility on a 5-acre parcel in the Waiiau-Pearlridge area. A third corporation, Healthcare International is also due to bid for another private psychiatric hospital. SHPDA will be the final judge of which, if any, will be chosen to provide additional mental health beds . . .

The Big Island, including Kona, has a chance to obtain more emergency medical services, but a State-County tussle is delaying the services. **John Chalmers**, head of the State's EMS, says that his office is waiting for a response from the County on a State offer to provide funds for additional services. County Fire Chief Donald Thompson says his department does not have enough men trained as Emergency Medical Technicians (EMT) to enter into a contract with the State. Thompson says he has to come to a reasonable agreement with the union about personnel. But Steve Querobin, union representative for the fire fighters, maintains there is no such hangup between the County and the union. "The problem is with the State which is playing games. If the State is willing to pay for the service, then they should come up with a proposal." (Ed. So everyone's passing the buck . . . eh?)

Miscellany

The little garden variety snail was left a large inheritance . . . He hurried down to the local Porsche dealer and picked out a black Targa beauty . . . The salesman ignored the snail until he was shown the snail's savings book . . . The snail then asked the salesman to have a large "S" painted in phosphorescent white on the top . . . The salesman was curious, "Why do you want the 'S' painted on the top?" The snail replied, "It's been my life dream to drive such a car so people will say, 'Just look at that S car go!'" (As told by an unidentified MC at a recent wedding reception)

Do you know that the original sin didn't involve the apple in the tree, but rather the pear on the ground? (As told by our ever witty friend, Ben Higashi)

Life In These Parts

An August 6 *Honolulu Star Bulletin* editorial entitled, "The Problem of Too Many Doctors" points out that "Too much of a good thing is the prospect facing the nation when it comes to the supply of doctors . . . Ten years ago, there were 323,000 active physicians in the United States. Today, there are 444,000. By 1990, the figure may reach nearly 600,000. That would mean 242 doctors for every 100,000 people compared to 171 in 1974. At present there are 67,000 students in U.S. medical schools, twice the number in 1968. The Carter administration considers that too many and thinks the time has come to reduce government aid to medical education in order to curb the growth in the doctor population . . . One medical educator wrote that a doctor glut "will make the practice of medicine unpleasant, create cutthroat competition, force an increasing focus by the physicians on the monetary aspects of medicine, raise costs per patient workup, encourage the ordering of unnecessary tests and examinations and undermine efforts toward less-expensive preventive medicine." The editorial also points out that "the John A. Burns School of Medicine has been subjected to repeated challenges of its value in relation to its cost to the taxpayers of the state. Thus far the school's defenders have succeeded in fending off the critics . . . But with a national surplus of doctors looming and federal aid to medical education in jeopardy, it is probably going to be harder in the years ahead to justify state support." (Ed. We must all do some serious thinking . . .)

Professional Moves

As the saying goes, "When it rains, it pours!" The Year of the Monkey has been pussyfooting so long that we were beginning to wonder if the deluge we have been predicting will ever come to pass . . . Fear not, it started with July:

Chet Nierenberg, medical director, announced the opening of the Honolulu Sports Medical Clinic at 932 Ward Ave with the following specialized associates: **Robert Smith**, **Thomas Owens**, **Jack Scaff**, **Alan Nelson**, **John Wagner**, **James McGuire** and **John Cieply**.

The Kuakini Medical Plaza began to fill: former Straub neurologist, **Michael Okiihiro**, moved into Suite 810; neurosurgeon **Warren Ishida** opened in Suite 609, and pulmonary medicine men, **Edward Morgan** moved into Suite 405 and **Stuart Sugihara** moved into Suite 502.

Cardiologist **Raymond Itagaki** joined the Straub Clinic and internist **Scott Himeda** joined the Honolulu Medical Group . . . Internist **Ramond Tam** moved into Suite 612 at Queen's Physicians' Office Building . . . Dermatologist **Wayne Fujita** opened at Suite 401, Aiea Medical Building and psychiatrist **Danilo Lucila** relocated to Suite 208, Aiea Medical Building—OB Gyn man **Benton Chun** opened at Piikoi Medical Building and psychiatrist **Emily Khaw** relocated to Suite 1258, American Security Bank Bldg. . . **FP Jan Stephens Fyrberg** opened her Manoa Medical Clinic at Manoa Marketplace.

On the Big Island in Hilo, **FP Susan Gilbert** joined pediatrician **Ruth Matsuura** at Ka Waena Lapa'au (The Medical Center) at 670 Ponahawai St. and psychiatrist **H. Russell**

Pickering joined child psychiatrist Peter In at 190 Keawe Street. In Kona, FP **Rodney Thompson** joined the Kona Medical Associates, psychiatrist **Jeffrey Rome** joined the West Hawaii Psychiatry Associates, Inc. at 75-5722 Kuakini Highway, and general surgeon **Lawrence Peebles** opened at 75-5665 Kuakini Hwy.

On the Garden Island, FP **Paul Esaki** opened at 1111 Kealahoa Rd., Kapaa, Kauai (former office of K.K. Fujii who retired to the golf links) and surgeon **Robert Weiner** and pediatrician **Linda Weiner** opened their new offices in Kalaheo.

On Maui, OB Gyn man **Wolfgang Pfaeltzer** relocated to 31 Kamehameha Ave., Kahului, (**Kenneth Haling's** Clinic) and another OB Gyn man **Gerald Kushi** opened his office at The Maui Clinic, 53 Puunene Ave., Kahului . . .

We were intrigued by the following bold lettered ad: "Law offices of Dr. G.M. Flick, physician/attorney . . . Concentrates in Personal Injury Cases arising from the use of I.U.D.s . . . 733 Bishop St., Suite 2600, Grosvenor Cntr., Honolulu, Hawaii 96813"

Physicians Speak Up

Politically minded **Richard Chang** wrote: "The U.S. has been on an energy consuming binge, and it's time to take our medicine. Members of Congress know it, but only a few apparently are willing to say so publicly during an election year. Sen. Daniel Inouye and Rep. Cecil Heftel were among only 44 in Congress to support President Carter's 10 cent gasoline tax designed to reduce oil imports from the OPEC nations . . . The *Washington Post* called their stand 'courageous' (both face reelection this year) and congratulated them for sticking by their convictions. Heftel has gone even further by proposing a larger tax because he says the situation is so serious . . . Hawaii is among the most dependent of all the states on imported oil, and we, above all people, should know that Inouye and Heftel were voting in our own best interests."

The recent American Bar Association meeting in Waikiki listened to a 6-member panel on how to cope with stress. Psychologist **John Blaylock** prescribed "*musterbation*" which is the elimination of "*garbage*" which refers to widely held myths such as "everybody in this world *must* love me," "I *must* explain my life to everybody," "I *must* not fail," "I *must* have someone stronger than myself to rely on," and "I *must* worry about other people's problems." Cardiologist **Jack Scaff** told the audience that "stress can be handled with strenuous exercise which will eliminate from the body the biological products of anxiety . . . Stress in a fit individual is not necessarily bad." Psychiatrist **Antonio Dy** said "stress can be dealt with by *inoculation*, in the manner a parachutist learns to overcome his fear gradually; *reduction*, teaching the body to handle physical kinds of stress; *decompression*, reducing individual and interpersonal pressures; and *conversion*, transforming stress into a constructive force. Sex therapist **Carol Sims** explained that sex problems from stress should be treated by a "holistic" approach. She advised a positive attitude and cautioned that negativism in dealing with sexual problems can lead to "*self-fulfilled prophecy*" and "*sexual sabotage*." (Ed. We do hope the lawyers understood all the psychological verbiage better than we did . . .)

Sharon Bintliff, one of 12 Hawaii delegates to the 3rd White House Conference on Families in LA, felt that the Hawaii delegation got across the idea that "families must be seen in their cultural contexts by the makers of policy affecting families." (ie, what may be good for a family in Texas may interfere with the role of an extended family in Hawaii.) Sharon felt that unfortunately the delegation failed to get the conference to recommend that the federal government encourage all states to have a mandatory program of family life education in grades K through 12.

Sportsmen

Chet Nierenberg is the sparkplug behind the new Honolulu Sports Medical Clinic on the 4th floor of the Honolulu

Club . . . Chet says "The area of sports medicine is a fairly new specialty . . . The field includes more than the basic MD services . . . It delves into everything from exercise physiology to treadmill testing . . . It's a new service for runners, joggers, sedentary businessmen who want to start doing something athletic and don't know how to go about doing it, the recreational athlete, the young developing athlete who doesn't know how to go about training . . ." The other staff members include orthopods **Robert Smith** and **Tim Owens**, internist **Alan Nelson**, treadmill cardiologist **Jack Scaff**, radiologist **John Cieply**, physical therapist **Robin Smith** and exercise physiologist **Kori Phillips**. Chet says, "One common mistake people make when trying to get into condition is that they rely on just one sport. What I recommend is they take at least two sports they like doing and mix them on different days. It provides variety, it doesn't stress the body, and it gives a psychological lift. The two sports should be complementary. Pick one that exercises your heart—running, bicycling, swimming, racquet ball—and another you like."

Retired Straub pediatrician **Harold Sexton**, age 65, started swimming again over five years ago and lost 25 pounds and four inches off his waist within three months. Harold says, "Before I started, I couldn't pass a treadmill and now I can pass one with ease . . . I think swimming is one of the very best exercises for anybody of any age for safety, lack of injuries, use of all the muscles and good cardiovascular exercise . . ." In May, Harold won one bronze and four gold medals at the Masters National AAU Championship Meet in Fort Lauderdale and in June won three golds and two silver medals at the Second World Medical Games in Cannes, France. Since his triumphant return, Harold's taking it easy by playing tennis, going fishing and swimming only 2,000 meters a day for his health . . .

Elected, Appointed, & Honored

George Mills was re-elected to the AMA Board of Trustees recently in Chicago by the AMA's House of Delegates . . . The Hawaii Planned Parenthood board of directors for 1980-81 elected the following physicians as directors: Donniss Thompson, Angie Connor, Thomas Kosasa, Rick Williams and John Spangler.

Hors De Combat

Chicago attorney, Dennis Horan, told the ABA (American Bar Association) convention here that the courts fulfilled their function when they established standards required before treatment is withheld in a terminally ill patient. The patient must be in a terminal state where death is imminent, there is no form of life saving treatment available, and when treatment would uselessly prolong the dying process without hope of benefit or recovery. When these conditions have been met, the decision to withdraw medical treatment belongs to the attending physician. Only in those rare conditions where there is disagreement between the doctor and the family that cannot otherwise be resolved, can court proceedings be necessary. If the physicians violate the standards set by the courts, then homicide and tort laws will be called upon to correct the situation.

Birendra Huja feels strongly that the Alexander Young Building is a historic landmark. "I and my colleagues have talked to a good number of people from all walks of life regarding their feelings . . . and whether they are from downtown Honolulu or Waianae, the general consensus lies with saving the building and if anything, improving it."

We are happy to see that our colleagues feel the same about routine school and sports physicals on regular patients. Robert Dimler in his superb column which appears regularly in *The Windward Sun Press* writes: "Well, here it is July, and we're right in the midst of the pediatric season for physicals . . . Physicals for this and physicals for that . . . Some of the private schools still require annual physicals and 95% of these students, from A to Z are normal, healthy children and adolescents . . . If the child is well-known to the pediatrician's

office, another physical exam is not required, nor need it be done, unless the child has not been seen for two years or more . . . Kindergarten physicals are the only truly important ones . . . It's the tests that the lab tech and the nurses do (blood count, complete urinalysis, vision and hearing tests) not the ones that the doctors do, that are important . . . Like charred toast, this physical thing is overdone . . . One of these days some healthy high school student will walk in with a form for me to sign, declaring that he is physically able to climb the stairs to the third floor class. That'll be the day I'll throw up my hands in frustration, lock my doors, depart, and look around for some place to work and take care of people who are sick, because that's what I was trained to do in the first place . . ." (Ed. Sorry we had to extract so liberally from Bob's witty, humorous and informative column . . .)

In April **Philip Wolsk**, medical resident, was beaten to death in MacKenzie State Park on the Big Island and his fiancée Judith Panko was crippled in the same attack. Rewards totalling \$7,000 have been offered for information, but police have had no leads . . . Philip's parents have now filed a \$40,000,000 lawsuit against the state alleging that the state failed to take reasonable precautions to provide security to park users or give warning of dangers. (Ed. Perhaps this will shake up some state officials to take responsible action . . .)

John McDougall feels that 70% of the diseases in the United States are directly related to nutrition. The Michigan-educated physician began his research when he worked in Honokaa where he noted that the elderly Filipinos and Japanese were healthy while their children's health was a mess. He feels that the strongest epidemiological correlation is between breast cancer and fat intake and is now working on a three year study funded by the Straub Foundation to see if he can keep breast cancer patients alive longer by a diet change. John divides foods into four categories ranging from dangerous Category One to beneficial Category Four. His program is to eliminate the first category foods while increasing category four foods to 90% of the diet.

Category One: Nitrate-containing meats, such as ham, bacon and hot dogs. "Supermarket quality" meat. Hydrogenated and partially hydrogenated vegetable oils eg., margarine, vegetable shortenings; foods made with such oils such as imitation milk. Canned, bottled and packaged foods with artificial flavorings, colorings or preservatives. Pickles and other brine-pickled products. Talc-coated rice, charcoal broiled foods.

Category Two: (Foods to be eaten no more than once a week, in small amounts) Low fat yogurt, milk, cottage cheese, cheese, fresh fish, refined rice, flour, sugar.) (Foods to be eaten rarely, if ever: Range fed beef or organically grown poultry. Cream, milk, sodas, mayonnaise, eggs, chocolate)

Category Three: These are "rich" foods that may compose up to 10% of a healthy person's diet, but should not be eaten when ill: avocados, nuts, tofu, seeds, soy bean products, cold pressed vegetable oil, fruit juices, wheat germ, honey.

Category Four: These should make up 90% of a healthy person's diet: whole grains, milled grains (flour), vegetables, sprouted beans and seeds, beans and peas.

John and his wife Mary have a recipe book titled, "Making the Change" which he recommends for his patients . . .

"One person who's ignoring President Carter's Olympics ban is **Dr Richard You**, who left for Moscow. Dr You claims he received 'the necessary approval from the various agencies,' and would serve as chief medical coordinator for the international hospitality program during the games . . ." (from Dave Donnelly's Hawaii)

Visiting Professors

We were indeed fortunate to have two outstanding visiting professors at the QMC Friday morning sessions in August. The first was Barry Ramo from U of New Mexico who spoke on "A Practical Approach to Arrhythmias." Herein are notes from his lecture:

"Is treatment worse than the disease?"
PVC's: Very common and not necessarily a/c wider QRS

. . . Looked on as ominous sign in CCU . . . Spectrum ranges from benign to significant in acute MI's . . . Who to Treat?

- 1. Symptomatic ventricular arrhythmias
- 2. Out of hospital V.F. and no MI
- 3. Late post MI V tach . . .

Sudden Death:

Antiarrhythmic agents do work in post MI patients prone to recurrent ventricular arrhythmias. Incidence of sudden death mortality at 1 year post MI is down to 6% when treated with antiarrhythmic agents . . . In general, bypass surgery is not the answer.

High risk period is first 6 months to 1 year post MI . . . Do coronary angiography, stress test and Halter monitoring for evaluation . . .

John Hopkins Study: Sudden Death in 6 mos post AMI (Deaths/patients)

Ejection Fraction	Lown Grade Vent Arrhythmias		
	0-2	3-5	All
Greater than 40	0/33	0/3	0/36
Less than 40	0/19	8/26	8/45
All	0/52	8/29	8/81

"I do not treat patients feeling palpitations with no other manifestations of heart disease. (Like the princess and the pea or the prince and the pea story)"

"Framingham Study of isolated PVC's with no other cardiac disease concludes that resting EKG PVC's are not predictor of CHD or sudden death . . ."

"No therapy for stress induced PVC's unless ventricular tachycardia occurs . . ."

"Exercise V tach without evidence of CHD—No Rx"

"Dr Lown gets 70% reduction in arrhythmias with digitalization alone, but this has not been my experience . . . Must be the air in Boston"

"We use Lidocaine drip in MI patients, even though they are over age 70 . . ."

Our "Angels"

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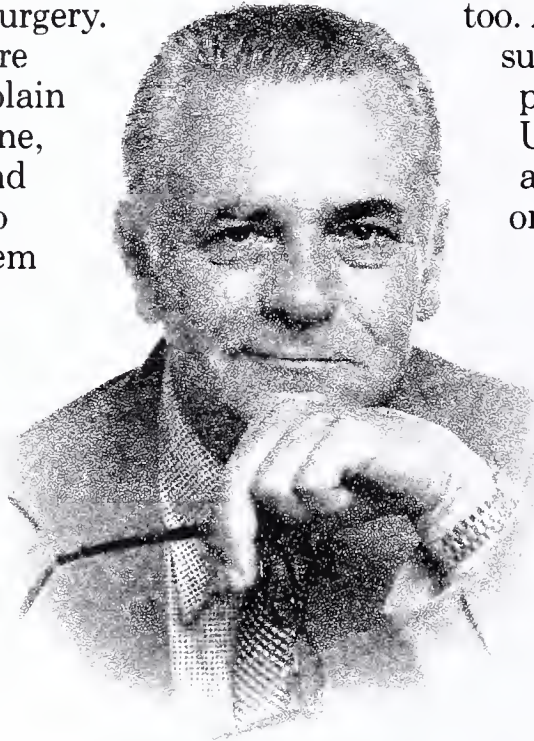
To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

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IN THE ANXIOUS HYPERTENSIVE PATIENT

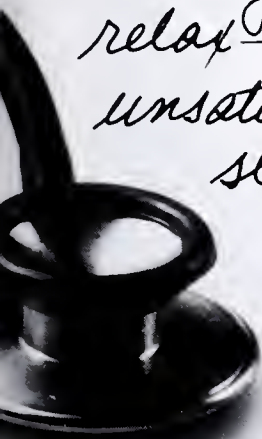
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muscle tension
inability to relax
unsatisfying sleep



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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

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Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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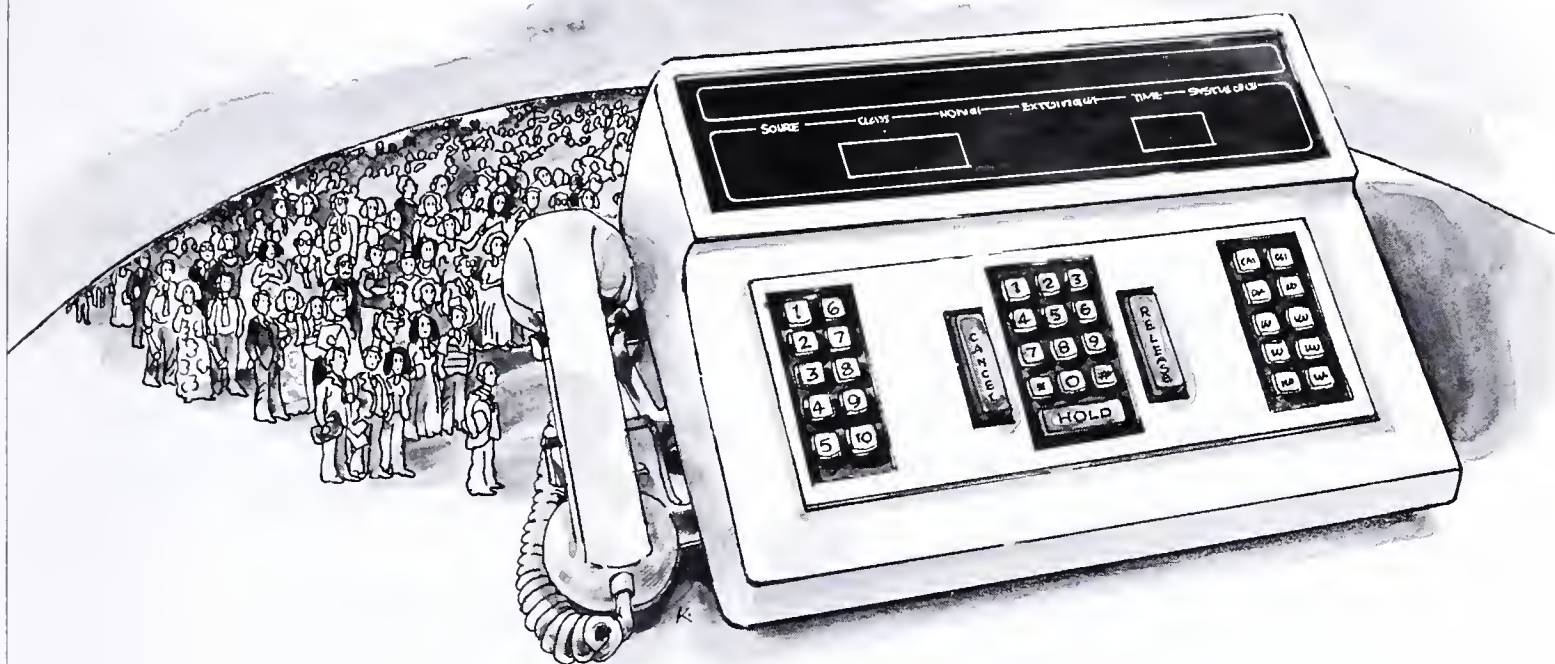
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Ethnic Differentials in Mortality in Hawaii, 1920-1970

ROBERT W. GARDNER,* *Honolulu*

A previous paper¹ has charted the course of mortality in Hawaii from 1878 to 1975. The mortality experience of the population of the islands has not been significantly different from the experience of other populations in terms of rate and age- and sex-patterns of mortality decline. The current level of mortality in Hawaii is among the lowest in the world, with the expectation of life at birth (e_0 in life-table notation) among the highest at approximately 76 years in 1975.

One of the most important and interesting features of the demography of Hawaii is its ethnic composition: no one ethnic group has an absolute majority of the population and, as of 1970, no fewer than 5 groups (Caucasians, Chinese, Filipinos, Hawaiians and part-Hawaiians, and Japanese) each had at least 6.8 percent of the total population.² The changing ethnic composition of the population and the relative socio-economic status of the different groups have always been of interest and are still so today. One objective indicator of status, in Hawaii as elsewhere, is the level of mortality. In this paper, the mortality of the State since 1920 is examined in terms of the position of the various numerically-major ethnic groups, using newly calculated and published life tables by ethnicity.³

Pre-1920 differentials

Robert Schmitt has previously examined differential mortality in Honolulu before 1900 (not the total State, or Territory, or Kingdom, for which data are not dependable, even if available for that period).⁴ Controlling for the different age distributions of the various major ethnic groups at that time, he found the lowest mortality to be among the Caucasians (Americans, British, and Portuguese), next lowest among the Chinese, higher than average death rates among the Hawaiians and part-Hawaiians, and ex-

tremely high mortality among the Japanese. (Filipinos did not start arriving until after 1900.⁵)

By 1910, using life tables based on data which are not entirely reliable, the ranking had changed slightly: Hawaiians and part-Hawaiians now had the highest levels of mortality, while the Japanese had been improving rapidly. (Filipinos were still too few to enable calculation of even partly reliable life tables.) It appears that a pattern had been established: non-Hawaiian immigrants, in the years immediately following their arrival in Hawaii, had a "death-filled history."⁴ However, as they became more established, their mortality fell rapidly, leaving the Hawaiians and part-Hawaiians once more at the bottom of the rankings. We can only surmise that this was true for the Chinese, it certainly was the case for the Japanese, and we may test the theory with the Filipinos below.

Ethnic differentials in life expectancy, 1920-1970

Life expectancy at birth (e_0) for each ethnic group is given in Table 1 and the data are presented graphically in Figure 1. In 1920 the most recent arrivals, the Filipinos, had the lowest e_0 values, approximately 33 years. The next lowest e_0 was for the Hawaiians and part-Hawaiians, with a life expectancy of about 35 years. The ranking of the other 3 groups was the same as it had been in 1910, with Caucasians exhibiting the lowest mortality.

Over the next half-century, however, much change occurred. By 1930, the Filipino e_0 had risen above that of the Hawaiians to fourth place among the 5 groups, and, with the exception noted below, it stayed there through 1970. In 1930, the Japanese had just about equalled the Chinese (e_0 for both of about 60 years), and by 1940 the Japanese life expectancy was the highest among the 5 ethnicities. The Japanese retained this position through 1970, the date of our most recent data.

By 1940, the Chinese had surpassed the Caucasians, occupying second place, where they

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Accepted for publication, February, 1980.

TABLE 1.—Estimates of Life Expectancy at Birth (e_0) by Ethnicity, Combined Sexes and by Sex, Hawaii, 1910-1970

		e_0 in years							
		CAUCASIAN	CHINESE	FILIPINO	HAWAIIAN	JAPANESE	OTHER ¹	TOTAL	RANGE ²
1910 ¹	M	50.80	54.94	NA	30.21	49.66	7.02	42.60	24.73
	F	56.46	61.31	NA	30.39	44.16	14.03	42.29	26.07
	T	52.90	56.36	NA	30.28	49.09	10.59	43.61	26.08
1920	M	55.01	53.93	32.79	35.91	51.28	28.32	46.95	22.22
	F	60.06	57.15	29.14	34.22	51.95	28.66	46.83	30.92
	T	57.02	54.75	32.95 ³	35.03	51.22 ³	28.95 ³	46.91	24.07
1930	M	60.05	57.95	47.36	42.19	58.39	33.15	53.65	17.86
	F	65.84	64.13	49.92	43.73	63.26	36.76	56.46	22.11
	T	62.39	59.60	49.88	42.92	59.89	35.40	54.82	19.47
1940	M	61.45	64.11	62.29	51.00	65.46	49.84	60.87	13.11
	F	70.51	67.84	61.95	53.83	70.80	59.67	66.06	16.97
	T	64.91	65.05	62.92 ³	52.35	67.46	53.99	62.84	15.11
1950	M	66.37	69.06	69.39	61.28	71.07	65.56	68.04	9.79
	F	73.94	70.90	69.36	64.03	74.47	71.09	71.89	10.44
	T	69.64	69.82	69.74 ³	62.64	72.57	67.63	69.63	9.93
1960	M	69.97	71.81	71.18	62.95	73.59	60.28	70.44	10.64
	F	76.18	76.41	72.12	67.06	77.59	65.64	74.79	10.53
	T	72.78	73.83	71.64	64.94	75.55	62.72	72.32	10.61
1970	M	70.68	74.78	70.21	65.05	75.71	75.25	72.03	10.66
	F	76.04	77.60	75.54	69.91	78.93	78.39	76.37	9.02
	T	73.19	76.10	71.79	67.46	77.30	76.88	73.97	9.84

NA = Not available

M = Males

F = Females

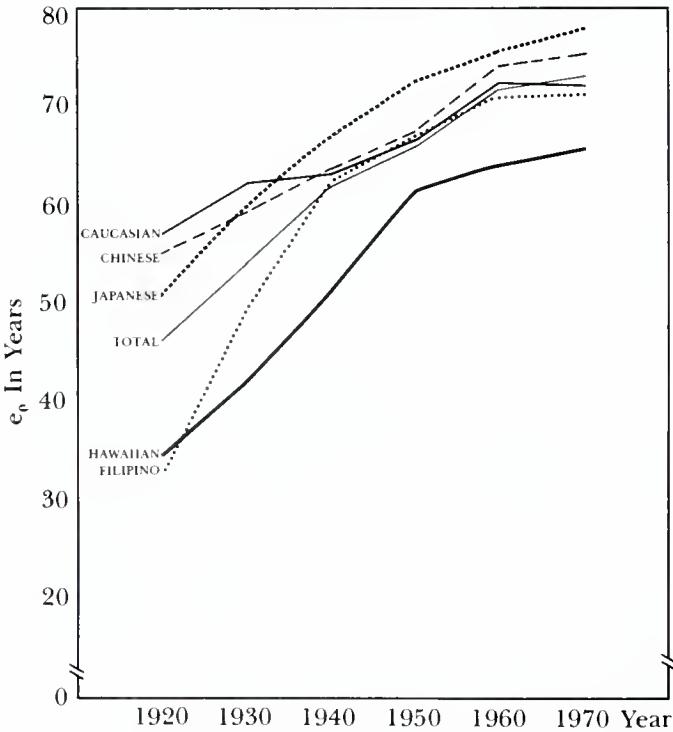
T = Combined sexes

1. The 1910 tables for all ethnicities and the "Other" tables for all years should be viewed skeptically.

2. Highest minus lowest e_0 ; excludes "Other."

3. Instances where the combined value lies outside the range of the separates sexes occur when the mortality schedules cross and the size of the populations of the two sexes differs markedly at some ages.

FIG 1.—Life Expectancy at Birth (e_0) by Ethnicity, Hawaii, 1920-1970



still are. The Filipinos, after passing the Hawaiians and part-Hawaiians, came close to the Caucasians and actually passed them in 1950, then fell back to fourth place overall, while the Caucasians currently rank third among the 5 groups.

The above changes have resulted in a narrowing of the "range" of life expectancy within the population of Hawaii: the difference between the highest and lowest values of life expectancy for any one year. In 1920, the range was about 26 years, but by 1970 it was a little under 10 years, having fallen steadily except for the 1950-1960 period. The phenomenon of convergence of life expectancy for sub-national populations is not restricted to Hawaii nor to different ethnic groups. For example, a study of mortality in Japan for the period 1950-1970 shows a definite narrowing of the gap between the prefectures with the highest and lowest levels of e_0 .^{6,7} Such a convergence can have at least two causes, which may work independently or simultaneously. First, there may be an increasingly even distribution among the various sub-populations of low-cost or free medical and public health provisions designed to lower mortality. Clean water and cheap vaccinations are two examples. Secondly, there may be an increasingly even distribution of wealth, eg, of the ability to afford good housing, good food, good health education and good medical care, all of which affect mortality levels. In this paper I do not attempt to unravel what forces were at work in the convergence of ethnic mortality levels in Hawaii from 1920 to 1970, but future work is planned on this topic.

TABLE 2.—Average Annual Change in Life Expectancy ($\bar{\Delta}$) by Ethnicity, Hawaii, 1920-1970

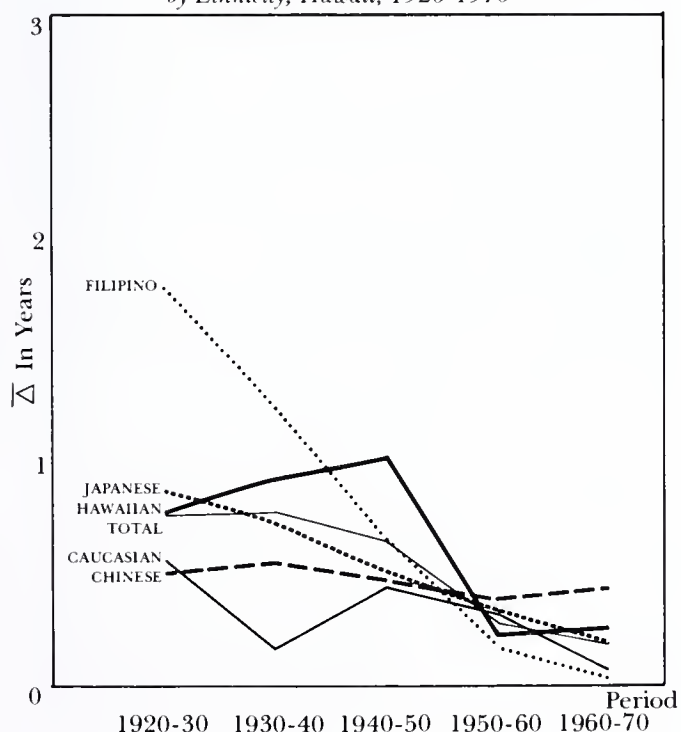
ETHNIC GROUP	1920-30	1930-40	1940-50	1950-60	1960-70	1920-70
Caucasian	0.54	0.25	0.47	0.31	0.04	0.32
Chinese	0.49	0.55	0.48	0.40	0.23	0.43
Filipino	1.69	1.30	0.68	0.19	0.02	0.78
Hawaiian	0.79	0.94	1.03	0.23	0.25	0.65
Japanese	0.87	0.76	0.51	0.30	0.18	0.52
Total	0.79	0.80	0.68	0.27	0.17	0.54

Source: Table 1

Rates of change

We may examine the change in life expectancy over the years to assess the relative rates of change for the different ethnic groups. This is, of course, a more precise way of looking at the slopes of the lines in Figures 1, and it confirms what we have already discussed, namely that convergence has been occurring. Table 2 and Figure 2 document the level of $\bar{\Delta}$, the average annual change in life expectancy. Without exception, the following is true: the lower that life expectancy was in 1920, the faster the rate of change for the next 50 years. Thus, Filipino life expectancy increased by about 0.8 years per year, while Caucasian life expectancy increased by only $\frac{1}{3}$ of a year per year. This intra-national pattern conforms to the experience of national populations as noted in Gardner and Schmitt: "The more recently the 'mortality transition' has come to a country, the more rapid its rise in e_0 ."¹

FIG 2.—Decadal Average Annual Change in Life Expectancy ($\bar{\Delta}$) by Ethnicity, Hawaii, 1920-1970



Looking at $\bar{\Delta}$, we find corroborating evidence for another feature visible on the life expectancy curves: the rate of change in mortality has decreased in recent years. For the total population, the rate of change has fallen steadily from around 0.8 years per year for 1920-1930 to less than 0.2 years per year for the 1960's. The separate ethnic groups show different patterns

of change, but all exhibit a fall from 1920-1930 to 1960-1970. The shapes of the curves in Figure 1 imply that life expectancy is approaching a maximum and that, given current technology, we may expect mortality rates for all ethnic groups to level off near those of the Japanese today. With regard to the US population as a whole, Keyfitz says, "It is almost as though the most favored sector of the population . . . shows us the way the rest of the population is going. Even if all social, racial, and sex groups could be pulled up to the same level as the most favored, the overall expectation of life would not be more than 80 years." He suggests that "future research should focus on what underlies . . . all (causes of death)—the deterioration and senescence of the cells of the human body."⁸

Sex differentials in mortality

The difference in mortality between men and women has been of great interest since it was first documented, and many attempts have been made to explain the reason for the difference.^{9,10,11} In this paper I am limiting myself to a brief description of the pattern of the sex mortality differential (SMD: female e_0 minus male e_0) for the different ethnic groups.

For the total population, the SMD rose, if irregularly, from 0.12 years in 1920 to 4.34 years in 1970 (Table 3, Figure 3). This pattern is not at all unusual and has been observed else-

FIG 3.—Sex Difference in Life Expectancy (Female e_0 Minus Male e_0) by Ethnicity, Hawaii, 1920-1970

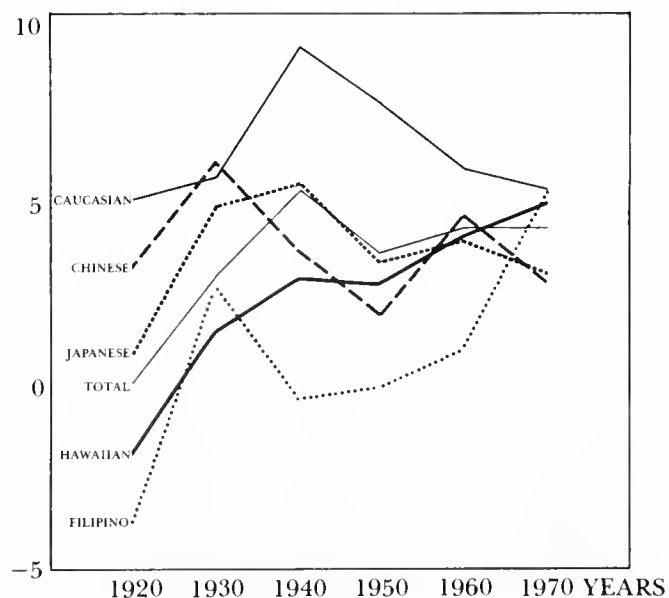


TABLE 3.—Sex Differences in Life Expectancy (Female e_0 minus Male e_0) by Ethnicity, Hawaii, 1920-1970

ETHNIC GROUP	1920	1930	1940	1950	1960	1970
Caucasian	5.05	5.79	9.06	7.57	6.21	5.36
Chinese	3.22	6.18	3.73	1.84	4.60	2.82
Filipino	-3.65	2.56	-0.34	-0.03	0.94	5.33
Hawaiian	-1.69	1.54	2.83	2.75	4.11	4.86
Japanese	0.67	4.87	5.34	3.40	4.00	3.14
Total	0.12	2.81	5.19	3.85	4.35	4.34

Source: Table 1

where.^{9,12,13,14} The overall pattern, however, is not paralleled by any of the ethnic groups, although all but the Chinese show a rise for the half-century following 1920. The patterns are erratic and suggest no immediate explanation. One might suspect the data, especially the definition of ethnicity, but there is no reason to suspect that definitions were being applied so erratically by sex as to account for the curves.

The problem may lie at least in part with the small size of the groups. Small populations can show fluctuations which are “ironed-out” in larger populations. An extreme example would be a population of only several dozen individuals: death rates would vary widely in such a population, with one year showing perhaps no deaths and the next year one or more. The larger the population, the smoother all changes and patterns are likely to be. Referring to the study of Japan mentioned earlier,⁶ we find that the SMD in Japan rose steadily from 1920-1925 to 1970, with one exception just after the end of World War II, but the SMDs for the separate prefectures often showed quite different patterns. Although all showed an increase in the SMD from 1920-1925 to 1970, there are numerous instances of falls in the SMD for shorter periods, and these form no consistent pattern.

Age patterns of mortality and mortality change

The variable of age is of great importance to all areas of demographic analysis and it is espe-

cially important in mortality analysis, because mortality rates vary so greatly by age. However, an age analysis of mortality can be quite involved. I can present here only a few measures of the age patterns of mortality and mortality change for the different ethnic groups in Hawaii.

Rao has developed what he calls a Relative Mortality Indicator (RMI).¹⁵ Based upon the nL_x and l_x columns of the life table, the RMI is the proportion of the possible years in any age interval which are actually lived by the life table members reaching the start of that interval, i.e., $\frac{nL_x}{ml_x}$. For example, if 90,000 males reach age 5 and live 828,000 person-years among them before reaching age 15, then they have lived 0.92 of the possible person-years they could have lived if no one had died in the interval: $(828,000)/(90,000,000) (10) = 0.92$. The RMI is thus 0.92. This index is useful because it allows us to compare mortality in age groups of different lengths.

Table 4 present RMI values for Hawaii's ethnic groups for 1920 and 1970, by sex. What is immediately apparent is that it is not always true that the group with any particular ranking for overall mortality, i.e., for e_0 , shows the same ranking for the 4 age groupings (which represent, respectively, early childhood, late childhood, adulthood, and late adulthood). The different ethnic groups use different paths (or weightings of mortality at different ages) to reach their overall life expectancies.

There are several other features of interest in Table 4. Not unexpectedly, late childhood has

TABLE 4.—Relative Mortality Indicator: Proportion of Total Possible Years Lived in Broad Age Intervals by Sex and Ethnicity, Hawaii, 1920 and 1970

ETHNIC GROUP	MALE				FEMALE				BOTH SEXES			
	0-4	5-14	15-54	55-74	0-4	5-14	15-54	55-74	0-4	5-14	15-54	55-74
1920												
Caucasian	.913	.989	.873	.725	.924	.990	.901	.803	.918	.990	.885	.754
Chinese	.903	.985	.872	.738	.928	.989	.866	.797	.915	.987	.868	.741
Filipino	.601	.980	.814	.805	.640	.977	.728	.629	.620	.978	.801	.786
Hawaiian	.801	.973	.721	.592	.808	.971	.673	.584	.804	.972	.696	.589
Japanese	.866	.984	.870	.754	.883	.984	.836	.817	.874	.984	.853	.765
Total	.848	.982	.834	.712	.864	.983	.808	.720	.855	.983	.823	.714
1970												
Caucasian	.979	.998	.977	.790	.984	.999	.982	.882	.981	.999	.979	.833
Chinese	.984	.998	.979	.863	.987	.998	.983	.913	.986	.998	.981	.887
Filipino	.976	.998	.958	.814	.982	.999	.975	.900	.979	.998	.967	.829
Hawaiian	.976	.998	.937	.737	.980	.998	.965	.796	.978	.998	.951	.766
Japanese	.983	.998	.976	.893	.986	.999	.986	.934	.985	.999	.981	.912
Total	.978	.998	.971	.832	.983	.999	.981	.896	.981	.999	.976	.860

Source: Life tables of ethnic groups in Hawaii, revised version, East-West Population Institute

TABLE 5.—*Change in Relative Mortality Indicator by Broad Age Groups, Sex, and Ethnicity, Hawaii, 1920-1970*

ETHNIC GROUP	MALE				FEMALE				BOTH SEXES			
	0-4	5-14	15-54	55-74	0-4	5-14	15-54	55-74	0-4	5-14	15-54	55-74
Caucasian	.066	.009	.104	.065	.060	.009	.081	.079	.063	.009	.094	.079
Chinese	.081	.013	.107	.125	.059	.009	.117	.116	.071	.011	.113	.146
Filipino	.375	.018	.144	.009	.342	.022	.247	.271	.359	.020	.166	.043
Hawaiian	.175	.025	.216	.145	.172	.027	.292	.212	.174	.026	.255	.177
Japanese	.117	.014	.106	.139	.103	.015	.150	.117	.111	.015	.128	.147
Total	.130	.016	.137	.120	.119	.016	.173	.176	.126	.016	.153	.146

Source: Table 4

the lowest mortality levels: almost no one dies between age 5 and age 15. At the other end of the scale, the late adult ages (55-74) have the highest RMI in all cases except two: Filipino males and females in 1920, where overwhelmingly high early childhood mortality is higher than at any other age. Otherwise, the rankings by broad age group are the same for both years for all ethnic groups: age group 5-14 has the lowest RMI, followed by groups 0-4, 15-49, and 50-69. The ranking by broad age groups for Hawaii for both years is the same as for the U.S. since 1949-51, but earlier there were somewhat different patterns for the U.S., with lower mortality at 15-49 than at 0-4.

The age patterns by sex reflect for the most part the lower mortality for females shown by the life expectancy analysis. However, there are several exceptions, most notably among the 1920 Filipino population, which was characterized by higher female mortality for all groups above age 5. When higher female than male mortality is found anywhere in the world, it is usually in the childbearing years and even then only in high-mortality populations.¹⁶ Here, however, the male advantage extends to the older adult ages. The Filipinos in 1920, newly arrived and having the lowest life expectancy by far, certainly exhibit marked deviations from the general age and sex patterns of the other ethnic groups. Part of this may be a result of the low numbers of females in the Filipino population in 1920 and the consequent random fluctuations in deaths; of only 4,180 total females, just 2,398 were age 15 and above.⁵ However, the males, of whom there were 16,581, also show peculiar age patterns for 1920.

Table 5 presents the 1920-1970 changes in the RMI. The values in this table are constrained by the initial (1920) values: no value can be more than one minus the 1920 value. Thus, the age groups and ethnic groups with the lowest values for RMI in Table 4 for 1920 have the highest potential values for Table 5.

Although, except for Filipinos, life expectancy rose faster for females than for males during the period under study, we find that at the younger ages the RMI increased more rapidly for males. At the adult ages, however, the reverse was true, and the RMI for females advanced faster. Rao's analysis of U.S. data indicates that as overall mortality falls, it is differences in mortality in the adult ages which dominate the overall sex mortality differential, and this observation is corroborated by our Hawaii data. This is so because at the younger ages, mortality is so low for both sexes that large differences are impossible: the largest male-female difference for the RMIs in 1970 at the ages below 15 was .006.

The age patterns of change in the RMI by ethnicity show Hawaiians and Filipinos leading the fall in mortality for almost every age for both sexes, the only exception being the anomalous older adult Filipino men. On the other hand, the ethnic groups with the highest RMIs in 1920, Caucasians and Chinese, show the smallest rise in RMI and hence the smallest fall in mortality. The convergence which was noted for the groups as a whole is thus definitely visible for the separate age groups as well: without exception, the range and the variance of the RMIs are lower for 1970 than for 1920. (These results are strongly influenced, of course, by the rapid rise which Filipinos and Hawaiians made from their 1920 levels. However, even among the three remaining groups, the range and variance of the RMIs fell from 1920 to 1970, with the exception of the oldest age groups, where some slight divergence occurred.)

Summary

Mortality for all major ethnic groups in Hawaii has fallen considerably during this century. There has been a definite narrowing of the differences among the groups, but the range between the highest and the lowest is still almost 10

TABLE 6.—*Female-Male Differences in Relative Mortality Indicator by Broad Age Groups, Sex, and Ethnicity, Hawaii, 1920-1970*

ETHNIC GROUP	MALE				FEMALE			
	0-4	5-14	15-54	55-74	0-4	5-14	15-54	55-74
Caucasian	.011	.001	.028	.078	.005	.001	.002	.092
Chinese	.025	.004	-.006	.059	.003	.000	.004	.050
Filipino	.039	-.003	-.086	-.176	.006	.001	.017	.086
Hawaiian	.007	-.002	-.048	-.008	.004	.000	.028	.059
Japanese	.017	.000	-.034	.063	.003	.001	.010	.041
Total	.016	.001	-.026	.008	.005	.001	.010	.064

Source: Table 4

years. At least for the plantation period, it appears that newly-arrived groups often had the highest mortality for a brief period after their arrival, but that they then improved rapidly and passed the group with longest residence in Hawaii but the poorest life expectancy: the Hawaiians and part-Hawaiians. The data indicate that the life expectancy of the Japanese in recent years may be viewed as a maximum for the other groups. Barring major new medical advances, little change in life expectancy, compared to ear-

lier rates of change, is expected in the near future.

The sex difference in mortality has increased in Hawaii since 1920 and this is true of all of the ethnic groups except the Chinese. The lack of a consistent pattern in this difference does not make predicting the future course of events easy, but it may be ventured that the sex-mortality differences among the various groups will move toward a common level.

REFERENCES

1. Gardner RW, Schmitt RC: "Ninety-seven years of mortality in Hawaii," *Haw. Med. J.* 37(10), October, 1978.

2. Gardner RW, Nordyke E: *The Demographic Situation in Hawaii*, East-West Population Institute, Paper No. 31, Honolulu, 1974.

3. Park CB, Gardner RW, Nordyke E: "Life Tables by Ethnic Group for Hawaii, 1920-1970," Hawaii State Department of Health *R&S Report No. 26*, June, 1979. These tables have been revised since their original publication, so the values in this paper are not exactly the same as the previously published values.

4. Schmitt RC: "Differential Mortality in Honolulu Before 1900," *Haw. Med. J.* 26(6), July-August, 1967.

5. Nordyke E: *The Peopling of Hawaii*, University Press of Hawaii, Honolulu, 1977.

6. Gardner RW: *Patterns and Determinants of Mortality in Japan, 1950-1970*, unpubl. PhD dissertation, U. of Calif., Berkeley, 1974.

7. Spiegelman M: "Significant Mortality and Morbidity Trends in the United States since 1900," American College of Life Underwriters, Philadelphia, 1960.

8. Keyfitz N: Improving Life Expectancy: An Uphill Road Ahead; *Am. J. Pub. HLTH* 1978, 68(10).

9. Retherford RD: *The Changing Sex Differential in Mortality*, Greenwood Press, Westport, Connecticut, 1976.

10. Preston SH: "An International Comparison of Excesses in the Death Rates of Older Males," *Population Studies* 24(1), March, 1974.

11. Madigan FC: "Are Sex Mortality Differentials Biologically Caused?," *Mil. Mem. Fund Quart.* 35 (1957).

12. Verbrugge LM: "Sex Differentials—Morbidity and Mortality in the United States," *Soc. Bio.* 23 (1976).

13. United Nations Department of Economic and Social Affairs: *Population Bulletin of the United Nation*, No. 6, New York, 1963.

14. Stolnitz GJ: "A Century of International Mortality Trends: 11," *Population Studies* 10 (1956).

15. Rao SLN, "On Long-Term Mortality Trends in the United States, 1850-1968," *Demography* 10(3), August, 1973.

16. El-Badry MA: "Higher Female than Male Mortality in Some Countries of South Asia: A Digest," *J. Am. Stat. Assn.* 64 (1969).

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Bureaucracy and Sunlamps

More than 150 years ago, Thomas Jefferson remarked that "We have more machinery of government than is necessary, too many parasites living off the labor of the industrious."

No machinery of government grows faster than regulatory activity. In the last ten years, twenty-one new regulatory agencies were established, more than twice as many in any previous decade. Once created, they inflate rapidly. The Equal Employment Opportunity Commission, for example, grew from 780 employees doing very little with a \$12-million budget in 1970, to 3,891 employees now doing little more for \$135-million per year. There were 28,000 federal regulators in 1970; now there are 91,000! The Environmental Protective Agency (EPA) alone has 11,226 people doing something previously unnecessary.

Closer to medicine, the Food and Drug Administration (FDA) doubled in size during the past decade, by busying itself fussing and clucking over nitrates, contact lenses, Darvon, diet pop, food coloring, saccharin, Freon, phosphate detergents, and all sorts of things that probably don't deserve much attention.

Now, because some fools burn their skin and eyes by exposing themselves to sunlamps without heeding the warning labels thereon, those with the "itch to regulate" are at it again. The Division of Biological Effects (DBE) of the Bureau of Radiological Health (BRH) of the FDA has issued mandatory Sunlamp Safety Performance Standards which include warning tags, instruction labels, automatic timer, manual switch, goggles for all users, and a special base which prevents operation in regular wall sockets. One manufacturer claims the standards will more than triple the cost of their product.

Warning labels are one thing. But to complicate and discourage the use of relatively safe products, in a zealous effort to protect a careless few, while trebling the cost, seems the hallmark

of federal regulatory meddling. "If we do not halt this steady process of building commissions and regulatory bodies . . . we shall soon be spending billions more," said F.D.R. on March 2, 1930.

The only hope for curtailing the morbid obesity of monsters like the DBE of the BRH of the FDA is to stop their nourishment, which means turning off the money supply. Insofar as possible by legislation and otherwise, Americans have a patriotic duty to withhold financial support of the federal establishment, in order to halt expansion and force rational priorities on national government, in hopes of saving the Republic.

JMC

Satin Slippers

Once upon a time, people wore shoes made of genuine or imitation leather. They were satisfied with this footwear, because they neither needed nor could afford expensive satin slippers.

Then an insurance company started selling "foot insurance." Strangely, people began to suffer from traumatoe, solescuff, heelhives, and other maladies, which were occasionally relieved by wearing satin slippers. In time everybody who had any problem with their feet was demanding satin slippers, rationalizing that "the insurance company will pay for them, anyway."

When the shoemakers protested this extravagance, their customers replied, "We know of someone who almost died of shoe allergy, until she started wearing satin slippers. If we're forced to take a chance and we get the allergy, we'll sue!" Shortly thereafter, a man with an ingrown toejam consulted his attorney, who conceded that it might be due to shoeshock. Luckily the shoemaker had malcobbler insurance, and his company advised settling out of court. From then on the shoemaker, his insurance rate climbing, took no chances; he turned out nothing but satin slippers.

Naturally the cost of satin zoomed, so the government predictably sent in an army of clerks with money to the rescue: *Pedicare* helped senior citizens, while *Pedicaid* would foot the bills of the poor. As expected, federal involvement soon kicked up the cost of everything: foot insurance, slippers, malcobbler policies, shoeorns, attorney fees, and especially, taxes.

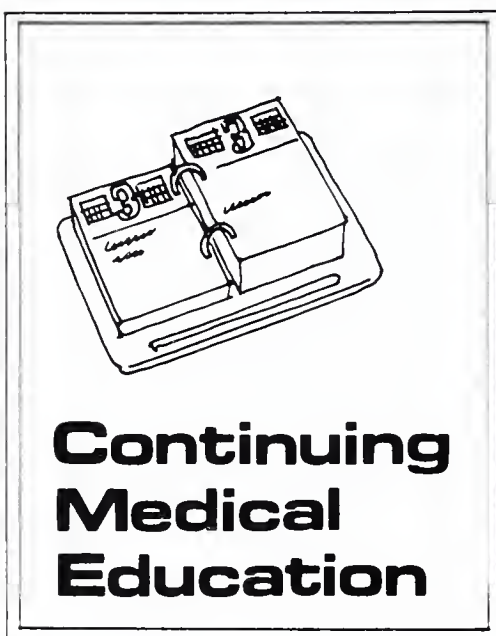
When the national cost of footwear really began to pinch, everyone—shoe customers, insurance companies, even some attorneys—concurred that the shoemakers were causing the high cost of footcare. They demanded that the federal government regulate footwear and "Footcare Providers" (the new term for shoemaker). Regulation required a host of new agencies, another army of clerks, and jillions of dollars. Congress poured billions more into Professional Shoemaker Review Organizations

(PSROs) and subsidies for experimental Health-foot Maintenance Organizations (HMOs), which peddled shoetrees, preventive massage, and pedicure. Opportunists proffered biofeedback, cornplasters, and feetupuncture, while demanding "provider" status. Footometrists lobbied for diagnostic drugs! While footcare costs threatened to bankrupt the nation, eager politicians proposed National Foot Insurance.

Meanwhile, the shoemakers protested that all this bureaucracy had nothing to do with the quality of footcare, and simply added to the cost.

Finally, people got tired of oppressive footcare taxes and long lines waiting for expensive satin slippers; some went back to wearing what they'd always worn before, and which, they discovered, worked almost as well most of the time. Still, they couldn't help wondering why shoemakers didn't know this. They began to suspect that shoemakers had preferred making satin slippers all along, because they're so much more expensive. After all, everybody knows "they're only in it for the money."

JMC



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.

- B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
 3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
 5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
 6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
 7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
 8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
 9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
 10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
 11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1.
 - A. **10/20/80**—Anals of Emerg. Med. (Aug 1980) 10-12 noon-Abstracts in ER Med (July 1980)
 - B. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 - C. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respi-cio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 - First—Didactic Presentation
 - Second—Perinatal-Neonatal Topics
 - Third—Obstetrics Topics
 - Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. Department of Ophthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
3. G. 1. Conference, Third Tuesday, 8:00-9:00 a.m.
4. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.

5. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
6. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, Third Thursday, 1:00-2:00 p.m.
8. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
9. Surgical Mortality & Morbidity Conference, Fourth Friday, 12:45-1:45 p.m.
10. Endocrine & Metabolism Conf., First, Third, Fourth & Fifth Wednesday, 7:30-8:30 a.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 - 1st—Dept. of Medicine
 - 2nd—Dept. of Surgery
 - 3rd—Dept. of OB/GYN
 - 4th—Dept. of Pediatrics
 - 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

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1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

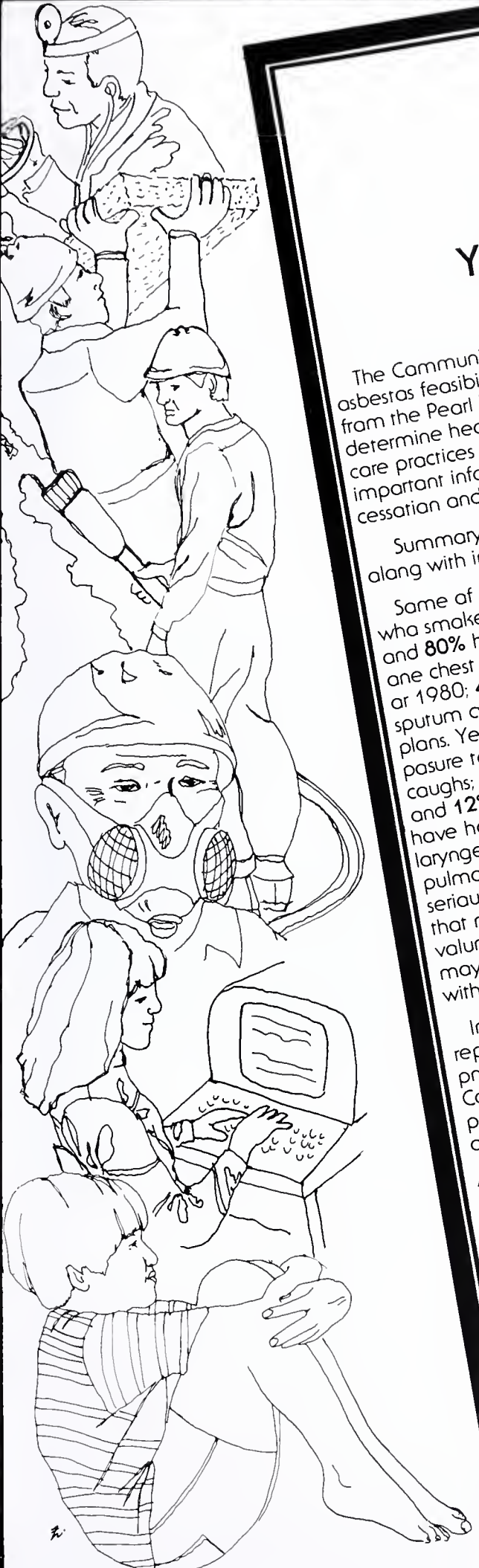
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

- | | |
|-----------------------|---|
| Oct. 3, 4, 1980 | Medicine in the 80's-State of the Art. 7:00-10:00 p.m.-10/3 9:00 a.m.-8:00 p.m. 10/4. Held at Prince Kuhio Htl, Waikiki. Spons. HMA-co-sponsor Unity Church of HI & UH Schl. of Nursing. Contact: John Watson, M.D. (808) 948-8585. 7 hrs. Cat. I. |
| Oct. 5-11, 1980 | Recent Advances in Neurology-Spons: The Honolulu Medical Group Research & Education Found. & International Cntr. for Health Ed-Kauai. 25 hrs. Cat. I. Contact: Robt. M. Schmidt, M.D.-Internat. Cntr. for Health Ed., P. O. Box 3109 Lihue, Kauai, HI 96766, (808) 245-2121. Held at Kauai. |
| Oct. 7, 1980 | Services of the Blood Bank of Hawaii. 7:00 p.m. Blood Bank Bldg. 2nd Flr. Conf. Rm., Honolulu, 1 hour Cat. I. Sponsored by the Honolulu County Medical Society and HMA. |
| Oct. 7-11, 1980 | Annual Postgrad. Course & Scientific Mtg., Soc of Gastrointestinal Rad. Hyatt Regency Htl, Maui. 23 hrs. Cat. 1. Contact: Mary J. Ryals, P.O. Box 2305, LaJolla, CA 92038 (714) 459-9787. |
| Oct. 11, 19, 1980 | Fifth Annual International Body Imaging Conf., Dept. of Radiology at West Park Hsp, Canoga Park, CA 91304. Held at Kauai Surf Htl, Kauai, HI. |
| Oct. 13-17, 1980 | 124th Annual Scientific Meeting, HMA. Held at Pacific Beach Htl., Waikiki. 5 days, 8-12noon. Contact: HMA office (808)536-7702 for further info. |
| Oct. 16, 1980 | General & Special Medical & Surgical Aspects of Ophthalmology & the Subspecialties of Ophthalmology. The Pacific Club, Honolulu, 7:30-8:30 p.m. Sponsored by the Hawaii Ophthalmological Society & HMA. |
| Oct. 18-25, 1980 | Western Orthopedic Assoc. Held at Hilton Hawaiian Village. Contact: H. Jacqueline Martin, Exec. Sec., 1970 Broadway, Oakland, CA 94612. |
| Oct. 25, Nov. 1, 1980 | Operative Arthroscopy, UCLA. Los Angeles, CA 90024, co-sponsor, J. A. Burns Schl. of Med, (808) 947-8573. Held at Hyatt Maui, Maui, HI. |
| Oct. 30, 1980 | Leprolgy—Panel from Carville, LA. Thursday, 4-5:30 p.m. Queens Univ. Tower, Rm. 618. Co-sponsor Dept. of Hlth. HI & J. A. Burns School of Medicine, and HMA. Contact (808) 947-8573. |
| Nov. 3-5, 1980 | Recertification Course for ACLS Providers-HI Heart Assoc. CPR Cntr. of HI, 1301 Punchbowl St., S 203, Honolulu. 8 hrs. Cat. I; Fee \$150. Contact: Skip Kirkwood, Prog. Dir. (808) 531-0174. |
| Nov. 23, 30, 1980 | New Directions in Psychiatry, U of Wash., John N. Lein, M.D., Div. of CME, Box SC-50, Seattle, Wash, 98195. Co-Spons. J. A. Burns Schl. of Med. Held at Ilikai Htl., Honolulu. |
| Dec. 4-6, 1980 | "Gynecological Surgery," sponsored by the American College of OB/GYN. 16 hrs. Cat. I. To be held at Hyatt Regency, Waikiki. |



ASBESTOS Feasibility Study Yields Initial Results

The Community Cancer Program of Hawaii has just completed an asbestos feasibility study on 411 ex-asbestos workers. Most were from the Pearl Harbor Naval Shipyard. Interviews were made to determine health status, occupational and smoking history, health care practices and resources. Interviewees were provided with important information about asbestos and health, about smoking cessation and physician consultation.

Summary information was then sent to the workers' physicians, along with informational materials on asbestos related diseases.

Some of the initial results from the interviews are: **75%** of those who smoked cigarettes have quit; **86%** have their own physicians, and **80%** have regular medical checkups; **95%** have had at least one chest X-ray in the past, **65%** have had the last X-ray within 1979 or 1980; **46%** have had lung function tests; and **12%** have had sputum cytology; **98%** have coverage in one or more medical plans. Yet only **32%** have discussed with their physicians their exposure to asbestos. Re: respiratory symptoms, **24%** have chronic coughs; **33%** usually produce sputum; **9%** have persistent wheezing; and **12%** have shortness of breath when walking on the level; **10%** have had a diagnosis of cancer, including stomach, colon-rectum, laryngeal and skin. These initial results indicate a high prevalence of pulmonary complaints among this group, but do not indicate any serious unmet needs in these ex-workers. However, they suggest that most lab studies have followed symptoms, that patients do not volunteer information concerning their exposure and thus, physicians may need to spend more time discussing the occupational history with such patients.

In addition, through this program, five local radiologists, representing the major hospitals on Oahu, were sent to a pneumoconiosis training seminar sponsored by the American College of Radiology, for detection in chest X-rays of the early parenchymal and pleural changes marking asbestos exposure and increased risk of cancer. They are:

A-readers:

Virgil Jabe, M.D., Straub Clinic
Michael J. Meagher, M.D., The Queen's Medical Center
Eugene P. McKeown, M.D., Kaiser Foundation Hospital

B-readers:

Narmal Palk, M.D., St. Francis and Castle Hospitals
David Sakuda, M.D., Kuakini Medical Center

To obtain copies of the informational material on asbestos, please write to the Lung Program, Community Cancer Program of Hawaii, 1236 Lauhala St., Honolulu, Hawaii 96813.

Dec. 11-14, 1980

Am. Med. Joggers Assoc. Contact: Hugh S. Ames, Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.

Dec. 14-20, 1980

Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 7, 1979 Supplement to JAMA or call the HMA Office.



Friday, July 11, 1980

HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Lum, Hindle, Goto, Iaconetti, Kam, Hur, Chun-Hoon, Lumeng, Bruce, Cahill, Fong, Wigle, Fu, Newman, Mills, Char, Dang, Chang, Hellreich, Mr. Tom Rice, and Mrs. May Kim. HMA Staff present were: Messrs. Won, Ajifu, and Jones; Mmes. Chang and Wong.

CALL TO ORDER:

The meeting was called to order by President Bell at 6:00 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of June 1980 which indicated that HMA membership totaled 906 as compared with a total of 886 in June 1979.

REPORT OF THE TREASURER:

The May 1980 financial statement was reviewed in detail and approved subject to audit.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Medical Malpractice Insurance Crisis Committee: Dr. Philip Hellreich reported that Attorney John Ed-

munds has agreed to work with the committee to proceed with its efforts to petition for a rate review hearing, with the Hawaii Insurance Commission, against Argonaut. Mr. Edmunds has estimated that legal fees will amount to approximately \$15,000-\$20,000. While the committee has raised over \$10,000 in pledges, letters have been sent to all members, non-members, and hospitals to solicit additional monetary support. It is anticipated that Mr. Edmunds will travel to Pennsylvania in the future to research another group's experience with malpractice insurance.

B. Health Service and Care: Dr. Donald Char reported that SHPDA has requested HMA's assistance in developing criteria for differentiating the private practice of medicine from organized ambulatory health care facilities (for exemption from Certificate of Need). The criteria would be utilized by SHPDA to establish new certificate of need rules to implement amendments to Act 75. The Committee recommended: (1) that HMA reject SHPDA's request for assistance inasmuch as HMA had originally questioned the concept of the statute, and (2) that HMA try to amend the state health planning law to remove portions of the statute that govern the application of certificate of need regulations as they affect the private practice of medicine.

ACTION:

It was moved, seconded, and passed to accept the committee's recommendations.

C. Public Health: Dr. Thomas Cahill mentioned that HMA will hold its Annual Sports Medicine Symposium on August 9, from 8:00 a.m. to 4:30 p.m. at McKinley High School.

D. Medical Education: Dr. Nadine Bruce reported that postgraduate courses to be presented at HMA's Annual Meeting have been approved for Category I CME credit. Departments of the UH School of Medicine will be represented. In discussing CME recordkeeping, it was suggested by Dr. Dang that HMA consider keeping records of other categories of CME credits (in addition to Category I) for HMA members.

ACTION:

It was moved, seconded, and passed that HMA keep records of other categories of CME credits for members.

E. Internal Affairs: Dr. K. Y. Lum reported that the Bylaws Committee is preparing amendments to the HMA bylaws as directed by the 1979 House of Delegates. The officers also met to conduct their annual review of the bylaws and have recommended some amendments for submission to the committee. Programs for the HMA Annual Meeting will be sent to physicians in mid-August.

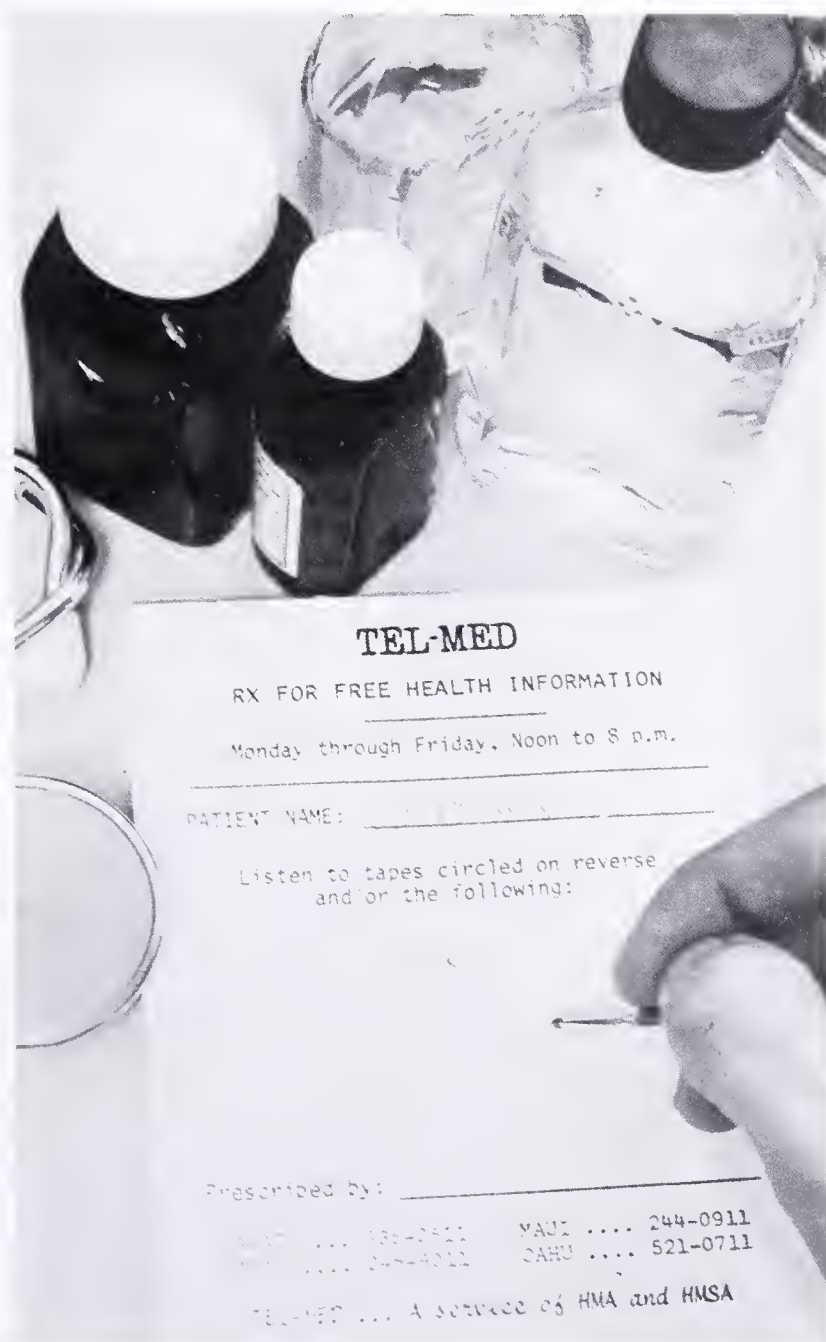
F. EMS: Dr. William Dang reported that the EMS program had prepared a 1203 grant application for the Department of Health, which subsequently was approved for EMS training on the neighbor islands. It is anticipated that the EMS program will be involved in this project. A recommendation was made that Council approve a corporate resolution to authorize the President or Executive Director to execute contracts (with the DOH, City & County, etc.) for services to be performed by the HMA-EMS Program.

ACTION:

It was moved, seconded, and passed to approve the corporate resolution for the EMS Program.

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G. Jail Health Committee: Dr. Walter Chang presented for Council's information and review, recommendations formulated by the committee and submitted to the DSSH. The recommendations represent possible courses of action that the DSSH may wish to take in order to meet the AMA's Jail Health Standards for accreditation.

ACTION:

It was moved, seconded, and passed to formally approve the recommendations submitted to the DSSH.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: In bringing Council up to date on HCMS activities, Dr. Calvin Kam reported that the Society held its last membership meeting on July 8 with an informative presentation by Dr. John Sheedy on "DSSH Monitoring of Physicians, Facilities, and Patients." The Society's Ad Hoc Committee on IPA's/HMO's recently met with various CHP providers. Issues arising from this meeting will be included in the program for the November membership meeting which will focus on HMSA's Community Health Program. Dr. Kam encouraged members to attend the Society's "Beer Bust" on July 27 being sponsored for medical students and residents of the John A. Burns School of Medicine. The Society's next meeting on August 5 will feature discussion on "DIU, Drugs, and the Physician." Dr. Kam briefly discussed members' reactions to the proposal of identifying HCMS members in the yellow pages of the Oahu telephone directory.

B. Maui: It was reported that Mr. Bernard Ho of HMSA was the featured speaker at the Society's last meeting. On July 18, a function will be held with Maui legislators at the Maui Hyatt Regency.

OTHER BUSINESS:

A. Leadership Conference: Dr. Bell encouraged Council members to participate in the HMA Leadership Conference on August 9 and 10, at the Ilikai Hotel.

B. Tax Planning Seminars: Mr. Jon Won reported that members' response to the tax planning seminars was overwhelming. In order to accommodate those on the waiting list, repeat seminars will be held on July 14 and 17.

C. Negotiations Seminar: Mr. Won reported that he will be consulting with AMA representatives regarding the possibility of holding a negotiations seminar in Hawaii sometime in the future.

D. Request from Honolulu Medical Group Research & Education Foundation: Dr. Bell reported that HMA received a request from the Honolulu Medical Group Research & Education Foundation for support of their efforts to establish in the State of Hawaii an IPA-model health maintenance organization. Due to the deadline given, the officers met to discuss the matter and agreed that HMA support the grant application of the HMG Research & Education Foundation.

E. Quackery Committee: A recommendation was made by the HCMS that HMA re-establish its committee on quackery as a subcommittee of the Peer Review Committee.

ACTION:

It was moved, seconded, and passed to re-establish a committee on quackery as a subcommittee of the Peer Review Committee.

F. Private Practice: Council reviewed a 6/24/80 memorandum from Dr. Calvin Sia requesting that Council consider the feasibility of establishing an ad hoc committee to study private practice. The proposed committee could develop "market strategies" for the private sector relative to the concept of free choice of physicians, look into costs of developing a public relations campaign, and meet with key members of business employers, union leaders, etc. to discuss free choice of physicians and medical costs.

ACTION:

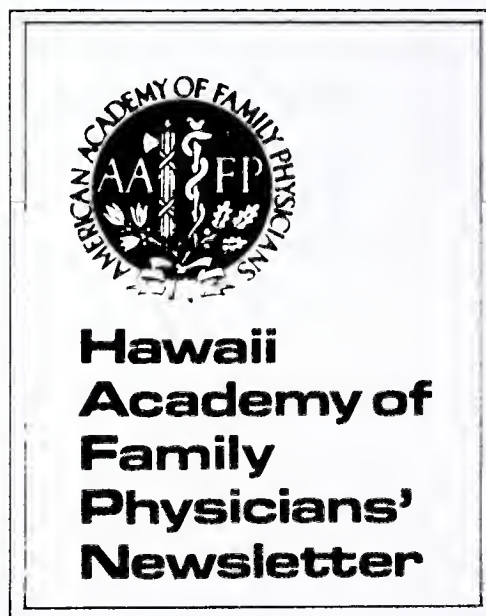
It was moved, seconded, and passed to establish an ad hoc committee on private practice.

G. Auxiliary: Mrs. May Kim reported that she will be attending the AMA Auxiliary's Annual Convention in Chicago. Mrs. Fu and Mrs. Kam will represent Hawaii as delegates. The HCMS Auxiliary is currently working on Guest Day to be held in 1981.

H. Report of Executive Director: Mr. Jon Won reported that Pacific PSRO will be separating from HMA as an independent organization as of October 1, 1980, as recommended by federal auditors. Mr. Andrew Saranchock, who was scheduled to return to HMA on July 1, has decided to remain with PacPSRO on a permanent basis as its executive director. Introduced to Council was Mr. Nelson Jones who will serve as Executive Assistant and assist in supervision of the financial management section.

ADJOURNMENT:

The meeting was adjourned at 8:25 p.m.



We welcome a new member this month: **James F. Conrad**, a resident in the U.H. FLEX program joins as a practicing affiliate member.

Our last dinner meeting at **Tom and Jinny Cahill's** beautiful mountaintop home in Aiea was attended by 41 members and guests. The program was especially well received this month. **Roland Tam** presented an overview of E.N.T. problems as they pertain to family practice; and **Nate Wong** gave a most interesting account of his voyage as a crew member on the Hokule'a,

accompanied by excellent slides. We even had two outer island members attend this time: **Jim Koch** from Molokai and **Arch Wigle** and his lovely wife from the Big Island. Arch is our newest Executive Council member and also a candidate for President Elect of HMA. He deserves our support. We look to see more of our neighbor island members at future meetings. How about it, Maui and Kauai?!

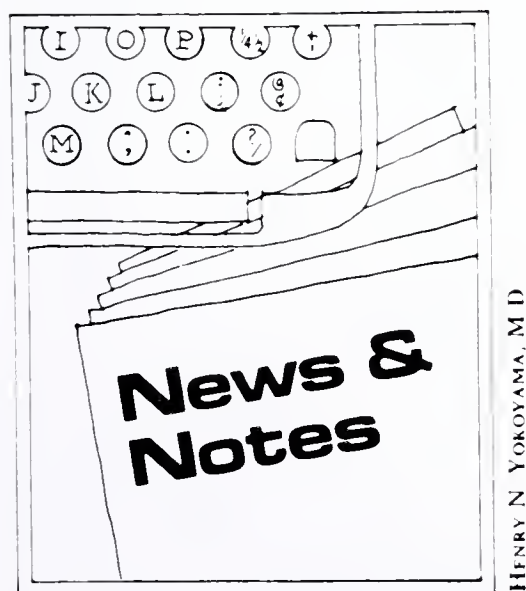
Our November dinner meeting will be hosted by **Dr. and Mrs. Bob Todd**. Bob is head of family practice at Tripler and this meeting should be of interest to house-buffs, since the Todds live at Fort Kam in one of the lovely old officer's homes of that area. More details on that will be forthcoming soon.

The **AAFP Annual Meeting** in New Orleans is just around the corner. Our chapter will be well represented at the Congress of Delegates by **Tom Cahill** and **Don Farrell** as delegates and **Kenneth Kern** and **Jim Tsuji** as alternates. For the delegates the congress is a real working session—they spend many hours in reference committees and on the floor. This year Tom has been assigned again to the reference committee on Healthcare Services and Don will be working on reports of officers and national committees. Both deal with controversial issues affecting every one of us as practicing physicians.

By the way, all Academy members attending the congress are invited to present their views before any reference committee. Here's your chance to be heard at the national level.

This year the AAFP meeting is being held in conjunction with WONCA (the world organization of family practice). **Don Farrell** will be presenting a paper on "The Use of the Micro-Computer in the Family Practice Office" at the WONCA sessions. He gave the same report locally at the annual Kaiser Symposium in September.

A few **CME** notes: Now is the time to send your yellow cards to Kansas City if you have not already done so, since the computer printouts will be mailed to members in early October. Please check your printout for accuracy and return corrected copies to headquarters if necessary. Also, if you have any feedback on last month's report by the Education Committee, please let us hear from you.



Life In These Parts

A 77-year old Japanese man with a chronic cough and a 15-lb. weight loss in 4 months was a 2-pack smoker till re-

cently. He was found to have a RLL mass on chest Xrays. Bronchoscopy biopsy revealed inflammatory tissue but no tumor cells. The chest surgeon was forced to explore and do a lobectomy despite the patient's diminished pulmonary reserve . . . The mass grossly felt like tumor, looked like tumor, even smelled like tumor, but the pathologist called it "pseudotumor . . ." We asked amiable pathologist **Larry McCarthy**, "How do we treat pseudotumor . . ." Larry's eyes twinkled as he smiled his shy smile and said, "With pseudo-treatment." . . . And we smiled happily too . . . with relief . . .

SATELLITES: In July, SF dedicated its Hilo Dialysis Facility at Hilo Hospital and in August, KMC dedicated its Wahiawa Dialysis Satellite at Wahiawa General Hospital . . .

"OVER EASY": **Dr. David Sinclair** can attest that police are getting tough on crime in Waikiki . . . The good doc was hauled into court last week for the high and heinous crime of lighting his pipe with a paper match and tossing the burned stub out his car window . . . (don chapman Aug. 25)

Tel-Med has expanded its tape library of health information to include several tapes in Ilocano, Samoan and Japanese. The library now includes 260 tapes. For a list of tapes available, write to HMA, HMSA or call 944-2398 . . .

Music man **Jose Romero** of Maui presented a violin and piano recital with Patricia Cottrell in the Cameron Center Auditorium in August. We learned that Jose wanted to be a professional musician, but war and family caused him to turn to medicine. During his school years, Jose played violin with the Manila Symphony and with the University of Louisville Symphony.

Senators Dan Inouye and Spark Matsunaga have introduced a bill in Congress that would expand Medicare coverage for mental health services. The bill would establish a 10-year commission to study and make recommendations on what additional mental health services should be reimbursed.

The HGEA which represents the professional nurses in the public sector raised the issue of school health aides administering medication to students. More than 700 children in public schools receive medication, sometimes two or three times a day to prevent seizures, and hyperactivity, etc. HGEA opines that only licensed nurses can give medication . . .

Paul Condit's Repertoire . . .

Arty, a killer for hire, hadn't had a contract for a while and was getting rusty. Someone contacted him about a contract, but the price wasn't right. Being a man of principles, he said, "Well, if you can't meet my price, I'll do it for a dollar." He decided not to waste bullets so when he found the victim in the supermarket parking lot, he quickly and mercifully choked him to death . . . Just then, he heard a muffled gasp from a car nearby. An elderly lady was sitting in her car and had seen the whole incident. He walked over calmly and choked her quickly. By then, the parking attendant came running after sounding the alarm. So Arty had no choice but to choke him, too. By this time, police cars had surrounded the parking lot and officers converged on Arty with drawn revolvers so he gave up without a struggle . . . The evening news headlines read "Arty Chokes Three For A Dollar At Local Supermarket!"

From The Mouths Of Babes . . .

(A career choice essay which inspired us . . .)

"Some may say I'm crazy. A medical career? Do you realize that you'll be spending your life forever learning? Yes, a medical career is a rigorous continuing process. It entails a willingness to make personal sacrifices and to pledge a total commitment to the welfare of others. If I were to choose one word to encompass this 'first aid' packet, it would be **MOTIVATION**—the driving force which provides the strength to strive, to achieve, and to expand. I can respect the person endowed with genius whose innate ability enables him to discern the complex world around him with such ease. I admire more the person who tries his very best, and whose endeavors reflect an unrelenting quest for knowledge and challenge. Both personally and academically, I am of this

latter group. Things never come easy for me. I have to study harder than others and I have to put forth my very best effort. However, I do not let academics rule my life, though perhaps it is a top priority.

A wise man once stressed to me the importance of a well balanced being. "A healthy body produces a healthy mind," he said. He'd wake me at 6:00 in the morning and we'd head for the nearby park to jog. Exercise helped me conquer my fears and suppress my anxieties about growing up. From jogging, I took up tennis, canoe paddling and swimming. Even when I left for college, his first question on our long distance phone calls would be "Have you been exercising?" He never emphasized academics. Perhaps he knew instinctively that I would be studying hard . . . I was never forced to study. I simply enjoyed the challenge and the competition.

Why medicine? It's the same challenge and competition. I cherish the idea of one day working with people, helping them find this same physical-mental balance in their lives. I am certain the fine correlation between physical and emotional fitness will have even greater meaning in medicine some day . . . I can think of no other field which offers this unique opportunity to help others by combining science and the personal touch.

To succeed, we must all pay our dues. What we expect from life can only be measured in our own efforts. Medicine seems to be the most challenging of the professional fields. And nothing inspires me more than the thought of dedicating one's life to its ideals."

Update In Diabetes

USC Assistant Professor of Medicine, Loren G. Lipson was here in May. The following are our notes from his pragmatic lecture on that ever controversial subject, diabetes:

"Type II diabetes is an interesting, yet controversial problem . . . Historically, diabetes is an old old disease . . . The symptoms of polydipsia, polyphagia, polyuria were described 2400 years ago . . . In India, the Susruta 1500 BC described the obese diabetic and recommended weight reduction as treatment . . ."

"The diagnosis of diabetes can be made two fold . . . Either there is evidence of pancreatic decompensation, or the way I make my diagnosis . . . The patient is feeling poorly, has an aunt who has diabetes, and he has sugar in his urine . . ."

Re: Oral Glucose Tolerance Test (Old USPHS Criteria)

	Blood Glucose	Serum Glucose	Points
FBS	110	130	1
1°	170	195	½
2°	120	140	½
3°	110	130	1
2 or more points=DM			

In reality 95 to 98% of diabetics can be diagnosed without this test; viz when FBS is greater than 140mg% or when the 2°pp blood sugar is greater than 200mg% . . .

Classification (Old)

	Juvenile	Adult Onset
Synonyms:	Ketosis prone Insulin deficient	Ketosis resistant Lipoplethoric
Age Onset:	Less than 25 years	More than 40 years
Type Onset:	Sudden	Gradual
Presentation:	Polyuria, polydipsia, polyphagia, acidosis	Often asymptomatic
Insulin requirement:	Usually	Often unnecessary
Nutrition:	Often thin	Usually overweight

Classification (New) (7 or 8 years old)

Type I	1DDM, Ketosis prone HLA related, islet cell Antibody pos	Type II (90%) NIDDM, ketosis resistant Not HLA related Antibody neg
Type 1A	Severely unstable C-Peptide neg	Type IIA Obese 1. Noninsulin requiring 2. Insulin requiring
Type 1A	Stable C-Peptide pos	Type IIB Non obese 1. Non insulin requiring 2. Insulin requiring
Type II	A Obese Diabetic (Maturity Onset) a. Has 5-10 times more insulin than thin normal person b. More insulin, but resistant to insulin	

	Action	Liver	Adipose	Muscle
Anticatabolic		glycogenolysis	lipolysis	protein catabolism
Effect		gluconeogenesis ketogenesis		amino acid output
Anabolic		glycogen synthesis	fatty acid synthesis	
Effect		fatty acid synthesis	glycerol synthesis	
Insulin	Stimulation of K transport			
Relative	Stimulation glucose uptake			
Amounts	Inhibition lipolysis Inhibition gluconeogenesis Inhibition glycogenolysis			

Re Insulin Receptors: a. Any cell that responds to insulin has insulin receptors eg RBC's, fibrocytes, monocytes, muscle cells, etc.

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- b. Under metabolic regulation, ie sensitive to metabolic changes
- c. Decreased insulin receptors in obesity and hyperinsulinism

Treatment of the obese hyperinsulin DM: Diet and *no* insulin

Why Treat Hyperglycemia?

1. Prevent blurred vision (2° hyperglycemia)
2. Control frequency of urination
3. WBC's do not phagocytize in hyperglycemic state
4. Cataracts (in rats, high b.s. causes increase in sorbital within the lens)

Senile cataracts are 8 times greater in diabetics

5. Peripheral neuropathy: High sorbital delays conduction (therefore 2° aldoreductase)

Treatment of Type II Diabetes

1. 80% of DM benefit by diet . . . Diet has to be life long
2. Weight loss is goal . . . Not necessarily ADA Diet . . . Stay away from easily broken down starches and concentrates of sugars . . . *In reality, if you get 20% to lose weight, you are qualified for sainthood.*
3. Oral Agents:
 1. Stimulates Beta cells to produce insulin
 2. Inhibits hepatic gluconeogenesis
 3. Increases the number of insulin receptors in peripheral cells . . .

Miscellany

A childless Alabama couple decided to find out the reason for their infertility and went to the local medical center. After the wife had been checked up on and found to be fecund, they suggested she go home and await her husband's return, since it would take a couple of hours for his tests. She went home, and when he finally arrived—an hour or two late—dressed to the nines: two-tone shoes, checkered slacks, a flowery sport coat, a loud tie, a sporty straw hat, and a cane which he twirled jauntily as he came up the front walk. "Well," said his spouse, "What's with all the fancy clothes?" "Well," returned her mate, "I figure when a man finds out he is impo'tant, he gotta *look* impo'tant!"

Visiting Professors

"There are big pukas in our knowledge on diet" admitted Dennis Meyer as he introduced James Cerda prof. of medicine, U of Florida who spoke on "Dietotherapy of GI Disease"

The following are notes from James Cerda's humorous yet informational lecture:

"True that physicians don't have much nutritional training . . . Phillip White in JAMA, 1961 wrote 'Over the years, fads on what to eat, have enjoyed an almost revered position in the therapy of gastrointestinal disorder.' Physicians use diets to punish their patients . . . Some of the dietary restrictions which have been imposed by physicians are: 1. Bland, 2. Sippy, 3. Milk & cream, 4. Boil and broiled, 5. No spice 6. Tasteless, 7. No alcohol and 8. No caffeine containing beverages . . . Milk is perhaps the worst antacid, and cream even increases gastric acidity . . . I don't know how many patients I have killed with this high cholesterol diet . . . The bland diet was banned at the U of Florida in 1972 when I got there . . . The Sippy diet is the world's worst punishment for the hospitalized patient . . ."

"Fiber doesn't bind bile juice . . . And vitamin C in orange juice is just as bioavailable as synthetic ascorbic acid . . . I don't know what food allergy in the adults is . . . I have never seen a bonafide case of food allergy in adults . . . only in children . . ."

i.e. Pathogenesis of Diarrhea: A. Lactose Malabsorption 2° to intestinal lactase deficiency . . . Parasites also wipe out the remaining lactase eg. the Thai's have practically no lactase . . .

B. Gluten Sensitivity: "Celiac Sprue" is a genetic disorder and the high risk groups are Irish and Jews . . . Dx by small bowel biopsy . . .

i.e. Flatus: I will not use "flatus" . . . Merriam-Webster says "fart." So I will speak of farting . . . Bacterial fermentation esp of beans and onions cause farting . . . Denny McLane of Detroit would fill up on beer and beans and constant farting was his major problem . . . We measured 86 plus-minus farts which was reduced to 24 by a low carbohydrate diet.

i.e. Food Allergy (in children): related to milk, nuts, fish, citrns, eggs, cocolates, peas, wheat, berries, corn . . .

i.e. Intolerance to fat: related to low chain triglycerides, insoluble fats and median chain triglycerides

i.e. Low Bulk Diets: Associated with low roughage diets

i.e. Dumping Syndrome: Treat with frequent meals

i.e. Acid-Peptic Disorders (heart burn): 20 to symptomatic reflux . . . Avoid anticholinergic drugs . . . Chocolate and milk affect the sphincter . . . Coffee, even decaffeinated, do not affect the sphincter but affect acidity.

i.e. High Residue Diet: 1. Billing quote: "A good reliable set of bowels is worth more to a man than a good set of brains." 2. Dietary fiber modifies: a. fecal output; b. fecal viscosity; c. fecal transit; d. flatus; e. bacterial flora; f. bacterial metabolism; g. bile salt excretion; and h. fecal extraction ie, short chain fatty acids . . . TIP From Consultant April 1980 p 209.

Reducing Paraphimosis

To reduce paraphimosis, take two gauze pads and firmly grasp the incarcerated prepuce at the 9 o'clock and 3 o'clock positions. Pull with increasing force, and at the same time, push your thumb down onto the glans penis. Adults may need to have the edema from the prepuce released by the multiple punctures from a 25 gauge needle (Care must be taken to make an accurate diagnosis of paraphimosis; this is not recommended for a gangrenous conditions)

George Kenessey, MD
Wahiawa, Hawaii

(Ed. Sounds like a painful situation wherein an ounce of prevention may be well worth a pound of cure . . .)

Surgical M & M

A 53 year old Italian man with anal fistulae, diarrhea and anorexia of 1 month duration was found to have Crohn's disease and CA of the sigmoid colon. He had an uneventful sigmoid colectomy and was discharged. He was readmitted with partial small bowel obstruction secondary to a *mushroom* bezoar and responded to conservative management . . . No questions were raised about the mushroom bezoar and we were curious. As we filed out of the conference room, we asked urologist **Bill Shiraki** and he offered the solution: "Too much pizza." Pathologist **Frank Fukunaga** said, "He probably ate a great big SHITAKE (A Japanese mushroom)". Surgeon **Noboru Akagi** remarked, "I have found bezoars quite common in my post gastrectomy cases." But we were still mystified how they managed to confirm a mushroom bezoar by X-ray . . .

Our "Angels"

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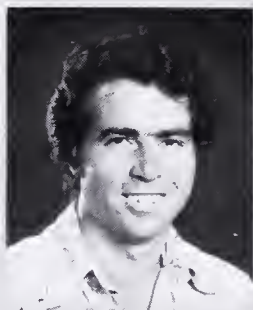
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**HAWAII MEDICAL ASSOCIATION
124th ANNUAL SCIENTIFIC MEETING**

OCTOBER 13-17, 1980

**PACIFIC BEACH HOTEL
2490 Kalakaua Avenue
Honolulu, Hawaii**



CURRICULUM

MONDAY, OCTOBER 13, 1980

8 a.m. - 12:30 p.m.

A1. OFFICE GYNECOLOGY-ENDOCRINE ASPECTS • This course covers the evaluation and management of the hairy female. Diagnosis and management of polycystic ovarian disease will also be reviewed as well as amenorrhea—work-up and evaluation. Office evaluation of infertility and practical aspects of endometriosis will be discussed. Case discussions will be included. **FACULTY:** Thomas Kosasa, M.D., John Marshall, M.D. (UCLA). **COURSE DIRECTOR:** Ralph W. Hale, M.D.

A2. RECOGNITION AND MANAGEMENT OF DEPRESSION

• This course is designed to acquaint the clinician in general medical practice with the signs and symptoms of affective illness, the differential diagnosis of depression, and the management of various psychiatric syndromes presenting with depressions. Differential diagnosis and modes of management of thought disorders will be addressed as well as the disorders presenting with anxiety. Evaluation of suicidal behavior and its management will be discussed. **FACULTY:** John McDermott, M.D., Andrew E. Slaby, M.D., Ph.D., M.P.H. (Providence, R.I.). **COURSE DIRECTOR:** Gordon Trockman, M.D.

A3. BASIC EKG • "Basic Electrocardiography: This course has been developed for the person with some but limited knowledge of the electrocardiogram. Characteristics of the normal electrocardiogram and their derivation will be presented and will include discussion of electrical axis. Attention will be directed to recognition of the common abnormalities affecting the QRS (ventricular depolarization) to include ventricular hypertrophy, intraventricular conduction defects and myocardial infarction. Disorders primarily altering the ST-T segments (ventricular repolarization) will also be reviewed to include consideration of effects of selected drug and electrolyte abnormalities." **FACULTY:** Melvin D. Cheitlin, M.D., (San Francisco). **COURSE DIRECTOR:** James Orbison, M.D.

A4. BILIARY-PANCREAS • New diagnostic modalities have revolutionized the evaluation of patients with disease of the biliary tract and pancreas. Ultrasonography, CT scans of the abdomen, endoscopic retrograde cholangiography (PTC) are now commonplace techniques. Their indications and limitations will be discussed. Recent developments in the dissolution of gall stones will also be discussed. In Hawaii biliary tract cancer is not uncommon and the Hawaii experience will be presented. A more aggressive surgical approach in cases of pancreatitis, both acute and chronic, is occurring and a discussion of the pros and cons of this approach will be presented. **FACULTY:** John Balfour, M.D., Gary Glober, M.D., Peter Halford, M.D. **COURSE DIRECTOR:** Thomas Whelan, M.D.

A5. WELLNESS: FAD OR SURVIVAL? • Discussion on prospective medicine and health hazard appraisal—a growing movement which involves among other things, improvement of health life styles. The latests in the exciting field of nutrition in prevention and therapy of disease will also be discussed. The environment risks of radiation hazards and what we can do about them will be another timely subject to be presented. The above will all be tied together into a program which promises to be interesting, educational, stimulating and which will go beyond preventive medicine into the area of high level wellness. **FACULTY:** John McDougall, M.D., Gregory Dever, M.D., Lewis C. Robbins, M.D., M.P.H. (Indianapolis). **COURSE DIRECTOR:** Frederick A. Dodge, M.D.

TUESDAY, OCTOBER 14, 1980

8 a.m. - 12:30 p.m.

B1. SEXUALLY TRANSMITTED DISEASES • This course will be geared mostly toward the general practitioner and the family practice physician, who are interested in the management and treatment of sexually transmitted diseases rather than the theories. The diagnosis should especially be noted, as the diagnosis is largely ignored.

Topics to be covered are the historical development of traditional sexually transmitted disease (GC and syphilis), modalities and those which do not respond to penicillin. Next will be the topic of PID, the clinical concepts and case presentations. Also presented before the break will be CDC, its uses as a national standard, management of PID, hypothetical cases, and a panel of the presentors who will discuss particularly Chlamydia and herpes, plan of management, seriousness of herpes, treatment outline and a summary and panel. Case studies will also be presented on these topics and questions to the panel will be encouraged from the participants. **FACULTY:** Raul Rudoy, M.D., Ned Wiebenga, M.D., Richard Arnest, M.D. **COURSE DIRECTOR:** Ralph W. Hale, M.D.

B2. PSYCHOPHARMACOLOGY • This course is to acquaint non-psychiatric clinicians with drugs commonly used in the management of psychiatric disorders and dosage indications and side effects in general medical practice. **FACULTY:** Eberhardt Mann, M.D., Andrew E. Slaby, M.D., Ph.D., M.P.H. (Providence, Rhode Island). **COURSE DIRECTOR:** Richard Markoff, M.D.

B3. BACK PAIN • The moderator will present a series of clinical cases typifying the complaints and findings of a group of patients with primarily back pain. Panel members will then go through the step by step process of analyzing those points in history, physical evaluation, laboratory and x-ray findings which lead them to a specific diagnosis. The panel will then discuss the treatment options available, stressing in-office treatment program. **FACULTY:** Robert Lindberg, M.D., Alan Pavel, M.D., Thomas Owens, M.D., Charles Barnes, M.D., Mary Tate, R.P.T., Kathy Huffman, R.N. **COURSE DIRECTOR:** Lawrence H. Gordon, M.D.

B4. GASTROINTESTINAL BLEEDING • Eight essayists will be concerned with massive gastrointestinal bleeding with stress made on aggressive approach to early diagnosis. Presentation will be made on the management of shock and explore the problems of blood replacement. Both the medical and surgical management of upper gastrointestinal as well as lower gastrointestinal bleeding will be covered. New methods of diagnosis and management such as esophago-gastro-duodenoscopy, colonoscopy and angiography will be presented. **FACULTY:** Myron Lezak, M.D., Peter Clap, M.D., Judson McNamara, M.D., Stanley Shimoda, M.D., James Crowley, M.D., Colin Dang, M.D., Robert Rose, M.D. **COURSE DIRECTOR:** Clifford J. Straehley, M.D.

B5. ARRHYTHMIAS • This course will review the basic types of arrhythmias and cardiac conduction disorders and their treatment. Ventricular and supra-ventricular arrhythmias will be analyzed and the common types of heart blocks discussed. Drug, surgical, and pacemaker treatment of arrhythmias will be explained. The course will begin with basic cellular electrophysiology. Ion dependence of the action potential will be detailed, and in particular the primary role of potassium and calcium. The anatomy of the cardiac conduction system will be reviewed and the relationship of atrial and ventricular depolarization to the EKG morphology will be elucidated. Representative examples of a wide variety of arrhythmias will be covered and audience participation will be used. **FACULTY:** Melvin D. Cheitlin, M.D. (San Francisco). **COURSE DIRECTOR:** John J. Cogan, M.D.

CURRICULUM

WEDNESDAY, OCTOBER 15, 1980

8 a.m. - 12:30 p.m.

C1. INFECTIONS IN CHILDREN • This course will be workshop designed to provide practicing pediatricians and primary care physicians with an in depth view of recent developments in diagnosis, assessment and management of pediatric patients with infections. Major topics to be covered are respiratory infections in infants, evaluation of the child with recurrent infections, sepsis and meningitis, management of acute gastroenteritis and review of current antibiotics. Sessions will be primarily presented in a format of informal didactic lectures allowing ample time for interchange of ideas between speakers and participants. **FACULTY:** Marian Melish, M.D., Paul Quie, M.D. (Minneapolis), Dexter Seto, M.D. **COURSE DIRECTOR:** Raul Rudoy, M.D.

C2. ALCHOLISM • This course is to acquaint the clinician with the many manifestations of alcohol use in general medical practice. Included will be the common psychiatric syndromes associated with excessive use of alcohol. General principles in the management of alcoholic patients will also be presented. **FACULTY:** Andrew E. Slaby, M.D., Ph.D., M.P.H. (Providence, Rhode Island). **COURSE DIRECTOR:** Bernice Coleman, M.D.

C3. OFFICE DERMATOLOGY • The course will include an overall view of office dermatology as seen by the primary care physician, including common dermatologic diagnostic and therapeutic problems and an update in "what's new" in clinical dermatology. The subjects include acne, sun and related skin disease, herpes simplex, malignant melanoma, cutaneous signs of internal cancer, hair loss problems, diagnosis and management of hand dermatitis, clinical therapeutic pearls, and "What's new" in clinical dermatology. **FACULTY:** Harry Arnold, Jr., M.D., Robert Clingan, M.D., Roman Glamb, M.D., Jay Greken, M.D., Robert Kim, M.D., Rees B. Rees, M.D. (Las Vegas). **COURSE DIRECTOR:** Allan Izumi, M.D.

C4. TRAUMA: THE FIRST 60 MINUTES • The management of the trauma victim during the first sixty minutes is probably the most crucial with respect to the long term mortality and morbidity. During this "golden preoperative hour" one must make a rapid and accurate assessment of the patient's condition and provide resuscitation and stabilization on a priority basis. This course will address the basic principles of initial assessment, resuscitation and stabilization, as well as discussing some of the common errors made during this most important hour. At the conclusion of this session one should have a firm grasp of the early diagnosis and management of life threatening emergencies involving the trauma victim. **COURSE DIRECTOR:** Peter Halford, M.D.

C5. NEUROLOGY PROBLEMS • **COURSE DIRECTOR:** Robert Hinman, M.D.

THURSDAY, OCTOBER 16, 1980

8 a.m. - 12:30 p.m.

D1. DRUGS AND THE TEENAGER • The course will focus attention on the changing patterns of drug and alcohol abuse among youth in this country. Pharmacology as well as the social impact of each of the drugs of abuse will be presented in detail. Special attention will be directed toward the use of Cocaine and PCP or "Angel Dust" by an ever increasing number of young people over the past few years. Effective means of intervention will be discussed in detail. **COURSE DIRECTOR:** Russell Hicks, M.D.

D2. DISEASES OF THE BREAST • This seminar on breast diseases will cover the role of the gynecologist, out-patient surgical treatment of the lump in the breast, xeromammography, pathology of the breast, role of the radiotherapist, new advancements in the management of advanced carcinoma of the breast, and breast reconstruction after mastectomy. Also included will be a discussion on the patient with carcinoma of the breast as a person. A report will be presented on the results of the Breast Cancer Demonstration Project. **FACULTY:** Carl Boyer, M.D., Paul Condit, M.D., Ann Catts, M.D., Fred Gilbert, M.D., Victor Hay-Roe, M.D., Jon Streltzer, M.D., David Sakuda, M.D., Thomas Teruya, M.D., Fred Warshauer, M.D., Robert Oishi, M.D. **COURSE DIRECTOR:** Charles S. Judd, M.D.

D3. THE SEPTIC PATIENT • Clinical manifestations of Septic Shock will be reviewed in this course with particular attention to its occurrence in patients with severe underlying diseases and altered defense mechanisms. Diagnostic and therapeutic measures used in the management of septic shock will be covered. The use of corticosteroid and antibiotic regimen will be discussed in detail, as well as adjunctive measures to support host defenses. **FACULTY:** Ralph Weinstein, M.D. (UCLA). **COURSE DIRECTOR:** William K.K. Lau, M.D.

D4. SPORTS MEDICINE • This course will be directed toward the general practitioner who is involved with patients in sports activities. Some of the topics included are: knee and shoulder injuries; back pain due to injuries; diving medicine; the use of radiology in diagnosis; sports as motivation for patients; and taping of athletic injuries. **FACULTY:** Chet Nierenberg, M.D., Gerald Mayfield, M.D., Allen B. Richardson, M.D., Kent Davenport, M.D., Jon Pegg, M.D., John Sipley, M.D. **COURSE DIRECTOR:** Robert L. Smith, M.D.

D5. RHEUMATOLOGY • This course is designed to provide the primary care physician, family practitioner, general or internist with current up-dated information concerning the commonly encountered rheumatic disease.

Emphasis will be placed upon the basic immunologic alterations that play an essential role in chronic joint disease. Attention will be focused on the immuno genetics that underlie host susceptibility in connective tissue diseases.

Practical aspects of the ordering and interpretation of laboratory tests in everyday practice of rheumatology will be discussed. An up-date on the clinical presentation of the following diseases will be covered: non-articular rheumatism, gout and pseudo gout, infectious arthritis, osteoarthritis, rheumatoid arthritis, sero-negative spondylo-arthropathies, and systemic lupus erythematosus.

Therapy of rheumatic disease will be covered by the following topics: conservative treatment of rheumatoid arthritis, the newer non-steroidal anti-inflammatory agents, plasmapheresis, gold and Penicillamine, present day treatment of SLE, and the role of orthopedic surgery in chronic synovitis.

A short question and answer period will conclude the session. **FACULTY:** Michael Catalano, M.D., Mary-Ann Antonelli, M.D., Racquel Hicks, M.D. **COURSE DIRECTOR:** Melvin Levin, M.D.

Medicine: "The Science of Treating Disease"...

Education: "Fostering the Need to Know"

FRIDAY, OCTOBER 17, 1980

8 a.m. - 12:30 p.m.

E1. GERIATRICS IN THE 80'S • The steady increase in the older population will continue in this decade. Since symptoms present differently in the elderly and diagnostic studies and treatment may require modification, four major geriatric areas will be reviewed: 1) Theories of aging in relation to the effects of age and environment on the cerebral functioning and 'pseudo-dementia'; 2) The relevance of nutrition for aging and associated physio-pathological tissue changes; 3) Surgery in the elderly and related metabolic and physiological problems; and 4) Urinary incontinence and its special features in the elderly. **FACULTY:** J. Brysson Greenwell, M.D., Clarence Hodges, M.D., Eduardo A. Porta, M.D. **COURSE DIRECTOR:** Stanley Batkin, M.D.

E2. ANTIMICROBIALS • Among the prerequisites for the rational use of antimicrobial agents are knowledge of the infecting micro-organism, the natural history of the disease, the relative advantages of the many available antimicrobial agents, and the specific disadvantages of each drug for that particular patient. This course will consider many of the major problems in infectious diseases in three categories: 1) Aerobic gram positive infections (streptococcal, staphylococcal, pneumococcal); 2) Aerotib gram negative infections (enteric gram negative rods, hemophilus, Neisseria); and 3) Anaerobic and miscellaneous infections. **COURSE DIRECTOR:** Richard Frankel, M.D.

B-3R. BACK PAIN • The moderator will present a series of clinical cases typifying the complaints and findings of a group of patients with primarily back pain. Panel members will then go through the step by step process of analyzing those points in history, physical evaluation, laboratory and x-ray findings which lead them to a specific diagnosis. The panel will then discuss the treatment options available, stressing in-office treatment program. **FACULTY:** Robert Lindberg, M.D., Alan Pavel, M.D., Thomas Owens, M.D., Charles Barnes, M.D., Mary Tate, R.P.T., Kathy Huffman, R.N. **COURSE DIRECTOR:** Lawrence H. Gordon, M.D.

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C5-R. NEUROLOGY PROBLEMS • **COURSE DIRECTOR:** Robert Hinman, M.D.

HAWAII MEDICAL ASSOCIATION 124TH ANNUAL SCIENTIFIC MEETING October 13-17, 1980 CALENDAR OF EVENTS

September 5,6 & 7	Annual Skin Diving Tournament	October 13, Mon.	Visit Scientific and Technical Exhibits, Marlin Room. 5 p.m. to 7 p.m. During the cocktail reception.
September 21, Sun.	Annual Deep Sea Fishing	October 13, Mon.	Computerized Electrocardiography—"The Physician's Assistant," 7 p.m. to 8 p.m., Mahimahi Room
September 24, Wed.	Annual Doubles Table Tennis	October 13-15 Mon., Tues., Wed.	Visit Scientific and Technical Exhibits, Marlin Room. 7 a.m. to 12 noon
October 8, Wed.	Annual Singles Table Tennis	October 14, Tues.	"Joining a Group or Partnership" Seminar, 1 p.m. to 5 p.m. Call BME, 536-9691 for registration/fee information
October 11, Sat.	Annual Singles Tennis Tournament	October 15, Wed.	HMA House of Delegates Reconvenes, 1:30 p.m., Ahi Room.
October 12, Sun.	Annual Doubles Tennis Tournament	October 16, Thurs.	Annual Golf Tournament, 10:00 a.m., Navy-Marine Golf Course
October 12, Sun.	Registration Desk opens, 1 p.m., Pacific Beach Hotel, Aikane Room	October 16, Thurs.	Annual Sportsmen's Night Party, 6:30 p.m., Cathay Room, Hilton Hawaiian Village, Golden Dragon Restaurant.
October 12, Sun.	"Managing The Business Side" Seminar, 8:30-5:30 p.m. (lunch included). Call BME, 536-9691 for registration/fee information.	October 17, Fri.	"Closing A Medical Practice" Seminar, 1 p.m. to 5 p.m. Call BME, 536-9691 for registration/fee information.
October 13-17 Mon. thru Fri.	Continental Breakfast for all registrants and participants, from 7-8 a.m., Aikane and Marlin Room.	October 17, Fri.	HMA Annual Banquet, cocktails at 6 p.m., dinner at 7 p.m., Pacific Beach Oceanarium Grand Ballroom
October 13-17 Mon. thru Fri.	HMA Postgraduate Courses, 8:00-12:30 p.m. (check your program).		
October 13, Mon.	HMA House of Delegates Opening Session and Reference Committee meetings. 1:30 p.m., Ahi Room.		
October 13, Mon.	HMA Hosted Cocktail Reception for registrants, exhibitors and guests, 5-7 p.m., Aikane and Marlin Room.		

For further information, call the HMA Office, 536-7702.

REGISTRATION

Please return to: HAWAII MEDICAL ASSOCIATION
320 Ward Avenue, Suite 200
Honolulu, Hawaii 96813

Inquiries: (808) 536-7702

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COURSE SELECTION

Date	Course No. First Choice	Course No. Second Choice	Course Fees (\$50 a course)
Monday, October 13	_____	_____	_____
Tuesday, October 14	_____	_____	_____
Wednesday, October 15	_____	_____	_____
Thursday, October 16	_____	_____	_____
Friday, October 17	_____	_____	_____

Registration Fee _____

TOTAL COURSE FEE REMITTANCE \$ _____

Payment must accompany registration.

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- ☐ \$27.00 - non-military

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- ☐ \$12.50 Doubles entry fee

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- ☐ \$5.00 Singles per person
- ☐ \$5.00 Doubles per person

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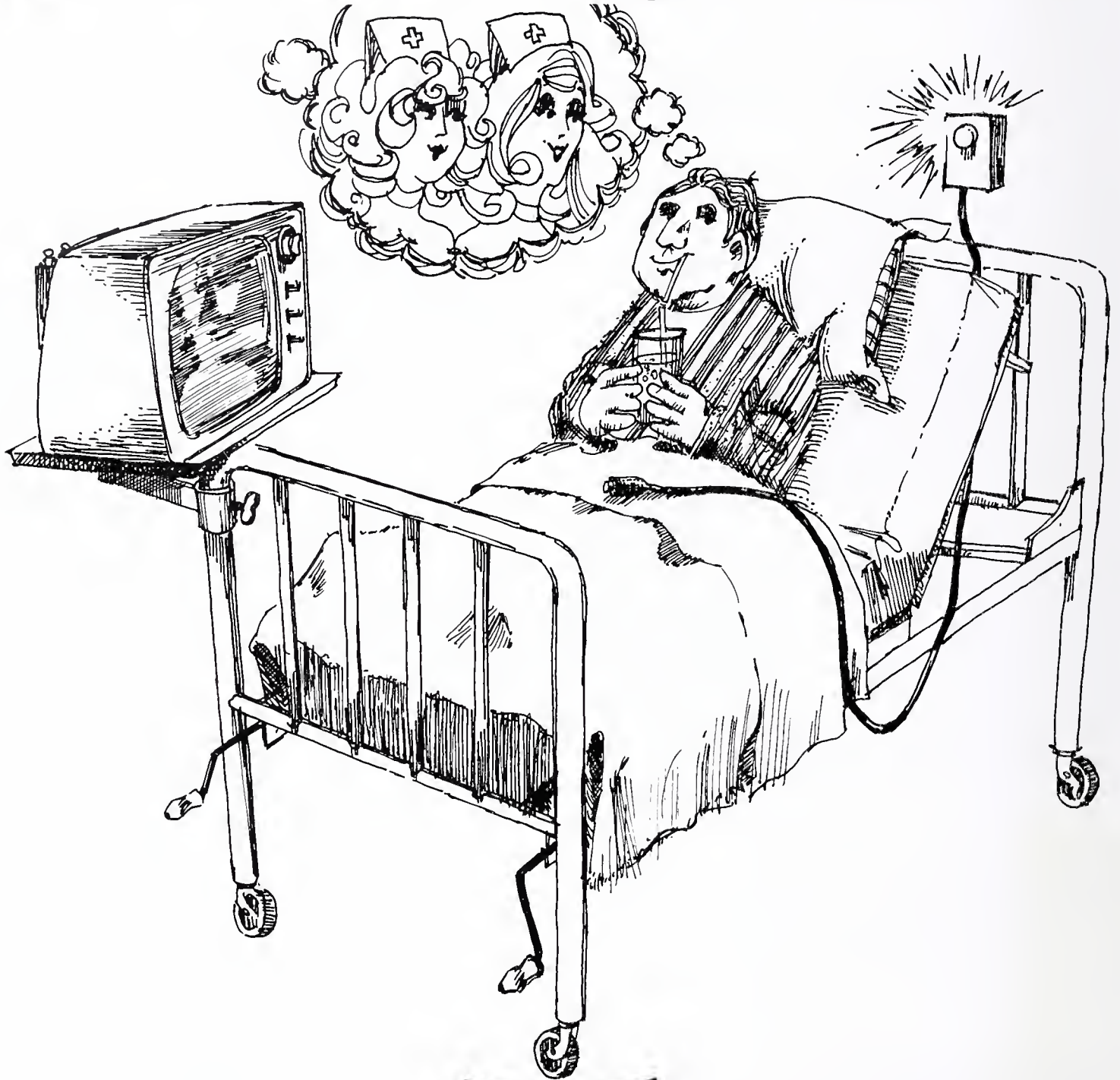
- ☐ \$30.00 Entry and boat fee
- ☐ \$10.00 Entry fee for boat owners

TOTAL FEE \$ _____

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Hawaii Medical Service Association

OCTOBER 1980
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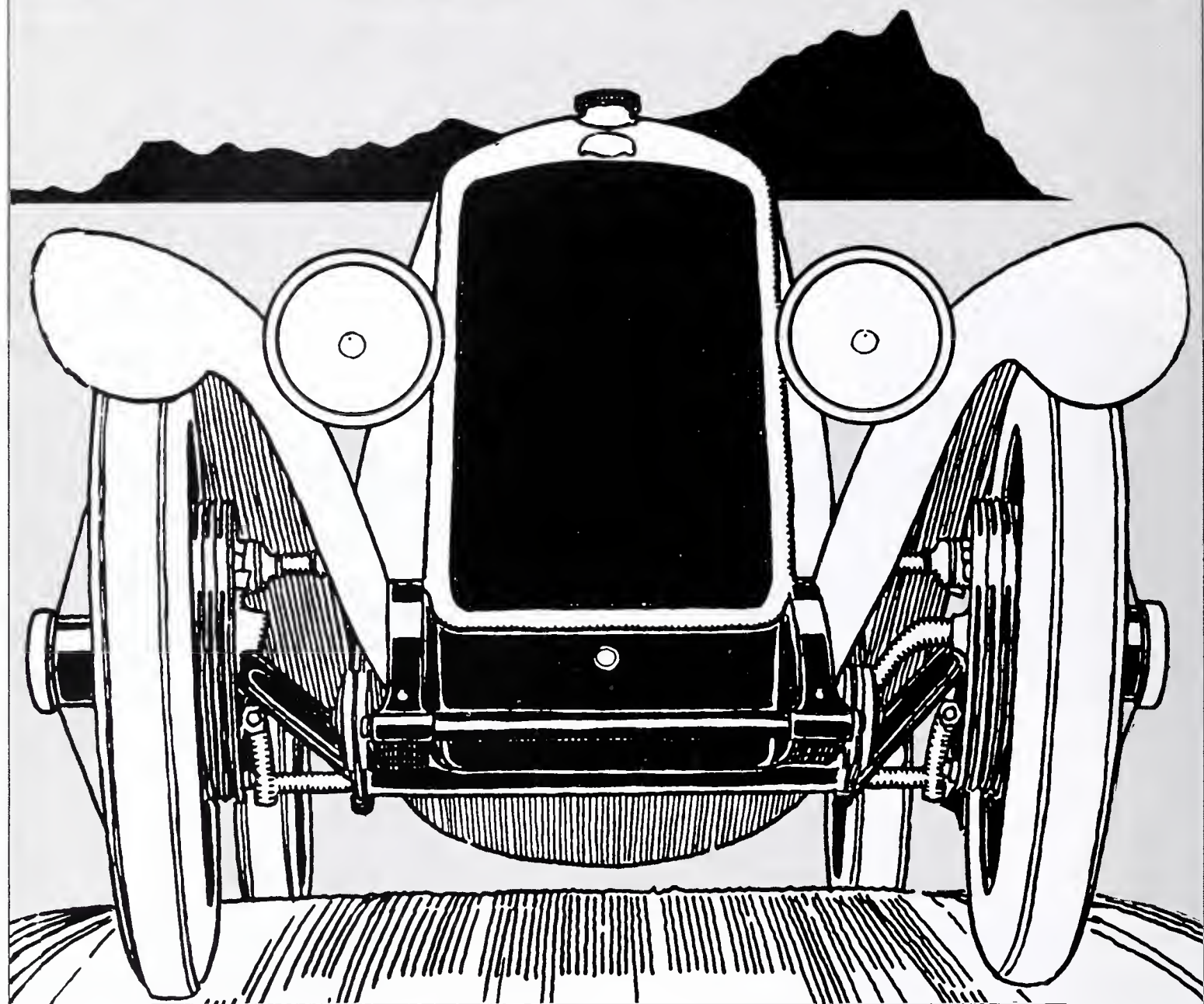
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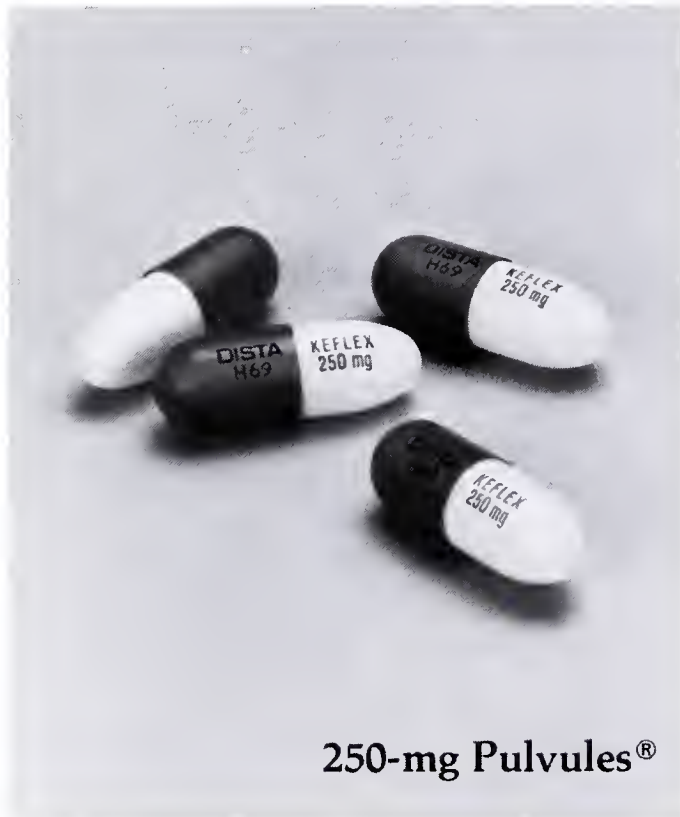


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Heroin Addiction and its Treatment in Hawaii: A Cross-Cultural Perspective

JON STRELTZER, M.D., ALTHEA MOLARTE, and
LARRY SEVERSON, M.D., *Honolulu*

● *Little is known about the influence of cultural factors on drug abuse. A record review of 255 heroin addicts applying for treatment at a drug treatment facility in Hawaii (DASH) revealed a disproportionate percentage of Caucasians, with relatively few Japanese and Filipinos. The excess Caucasians were accounted for by recent arrivals from the mainland. All groups had high dropout and readmission rates. We suggest that a comprehensive multi-modality treatment program is necessary to improve the treatment of heroin addiction in Hawaii.*

The subculture of the drug abuse community is well known both in the scientific literature and lay media. The importance of subculture phenomena has greatly influenced treatment approaches, including the widespread use of ex-addict counselors. Socioeconomic class is also known to be epidemiologically related to drug abuse. Culture and ethnic identity, however, have been infrequently examined. The few studies that have been done usually compare blacks and whites. A recent review of this literature indicated that while racial factors are probably important, the impact of culture and ethnicity on drug abuse treatment and its outcome is poorly understood.¹ The multi-ethnic society in Hawaii provides an unusual opportunity to look at these factors. This study describes characteristics of heroin users among the different ethnic groups of Hawaii and their utilization of the services of a large drug treatment program.

Method

Records from Drug Addiction Services of Hawaii (DASH) were utilized in this study. DASH offers counseling, referrals, detoxification, and methadone maintenance treatment modalities for drug abusers, excluding alcohol abusers. It is the only program in Hawaii licensed to provide methadone maintenance.

All records of new intakes during the period of January, 1976, through March, 1977, were reviewed. A total of 255 new clients applied for treatment of heroin addiction during this period; 12 others applied for barbiturate detoxification. Data were collected for the heroin users with regard to: ethnic group, age, sex, marital status, education, legal status, history of drug use, place of residence, length of time lived in Hawaii, family members with history of drug abuse, and treatment modality. Follow-up data were obtained 15-30 months after intake with regard to: outcome of treatment, reapplications for treatment, and referrals to other programs. The data were analyzed for each ethnic group.

Results

The ethnic distribution of the heroin abusers was significantly different from the general population as shown in Table 1 ($\chi^2=206$; $p<0.001$). Caucasians and blacks were markedly overrepresented, while Japanese and Filipinos were underrepresented. Only 21% of the subjects were married, and, notably for such a young population, 4% had suffered death of a spouse. Of the heroin users, 72% were high school graduates and an additional 6% had completed four or more years of college. Only 15% reported drug abuse in a family member, while 6% indicated alcoholism was present in their family.

From the Department of Psychiatry, John A. Burns School of Medicine. Dr. Streltzer is Associate Professor of Psychiatry, Ms. Molarte is a Medical Student, and Dr. Severson is the Medical Director of Drug Addiction Services of Hawaii. Reprint requests to: Jon Streltzer, M.D., 1356 Lusitana Street, Honolulu, Hawaii. 96813.

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TABLE 1.—Ethnic Distribution of 255 Heroin Addicts Compared to the General Population of Oahu (1976)

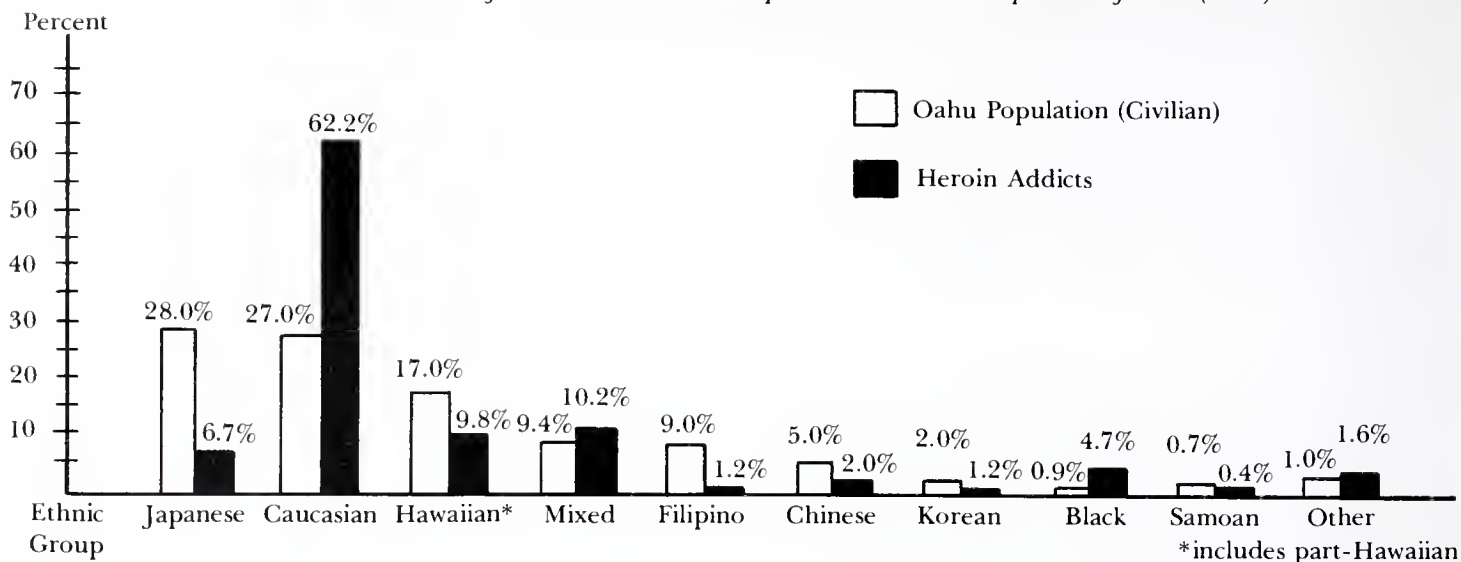


Table 2 shows the ethnic differences for a variety of factors. The striking finding in the large percentage of Caucasians and blacks who have lived in Hawaii less than 5 years, compared to the other ethnic groups where the vast majority had lived in Hawaii most or all of their lives ($p < 0.001$). Also noteworthy is that 54% of the subjects left the program and were admitted during the follow-up period and, indeed, the average number of readmissions was 2. There were no significant differences among ethnic groups with regard to dropout and readmission rates.

Twelve percent of the subjects were active with the program at the time of follow-up. One subject was receiving drug-free counseling and all the others were on methadone maintenance. Nine percent of the subjects had been referred to other drug problems. Six percent left the program for reasons out of their control, usually a jail sentence. Dropping out of the program after initial application prior to detoxification from heroin were 41%. Dropping out of the program after completing detoxification were 32%. Of these, 3 out of 4 completed the detoxification

period without evidence of drug abuse. There were no differences among ethnic groups with regard to these treatment results.

Discussion

The high percentage of Caucasians applying for treatment could be accounted for by the disproportionate number of newcomers to Hawaii in this group. The ethnic distribution of those who have lived in Hawaii 10 years or more roughly represents the distribution of population of major groups in Hawaii, although relatively small in their representation are Filipinos and Japanese. Immigrant groups other than Caucasians are not represented.

Does moving to Hawaii predispose a person to a higher incidence of drug abuse, or are the recently arriving Caucasians bringing their pre-existing drug abuse problems with them? A study of psychiatric emergencies in Hawaii reported several cases of heroin users coming to Hawaii—perhaps attempting to escape from their drug habit.² Nevertheless, some subjects deny drug problems on the mainland. It may be that young, single, unemployed Caucasian males

TABLE 2.—Percent of Heroin Users Having Various Characteristics Distributed by Ethnic Group

		CAUCASIAN N=159	BLACK N=12	HAWAIIAN N=25	JAPANESE N=17	OTHERS N=32	TOTAL N=255
Mean Age (Years)		26	33	29	25	29	27
Male*		59	92	80	94	61	67
Married		20	17	16	12	24	20
Years of Hawaii Residence***	>10	29	25	100	100	74	49
	5-10	25	9	0	0	16	18
	<5	46	67	0	0	9	33
	>16	6	8	0	18	5	6
	12-16	75	75	68	64	67	72
	<12	20	16	28	18	28	22
Employment	Unemployed	63	83	88	59	83	69
	Full-time work**	3	8	0	24	17	10
History of prior drug treatment		27	17	24	18	19	25
Readmitted to DASH		51	83	52	59	63	54
Active at follow-up		11	17	24	6	12	12

*** $p > 0.001$ ** $p > 0.01$ * $p > 0.02$

are particularly vulnerable to heroin use after arrival in Hawaii. An alternative explanation would be that "local" addicts are much less likely to apply for treatment, but exist in high numbers in the community, thus skewing our data. We suspect, however, that Hawaii does attract a drug-abusing population.

Another notable finding is the high dropout rate and high reapplication rate in the population as a whole. By far, outpatient detoxification from heroin was the service most often provided to addicts. However, only 32% stayed with the program the full 2 weeks required to complete detoxification. Of these, a quarter had positive urines for drug abuse at some point during the detoxification period. The vast majority of even those who stayed with detoxification soon dropped out of treatment. It is well known that detoxification alone is an ineffective treatment modality for heroin addiction.³

Many of these clients came back for second and third detoxifications. The picture thus emerges of a revolving door phenomenon, with the client applying for services, receiving detoxification, dropping out of treatment, resuming drug abuse, and returning for another detoxification at his convenience. It is even possible that such detoxification programs may be allowing drug abusers to maintain their habit by comfortably lowering their tolerance when the problem becomes too expensive or the supply is low. The revolving door phenomenon and high dropout rates are apparently common in mainland drug treatment programs also. By comparison a cross-national study recently reported even higher dropout rates: 81% for outpatient detoxification programs and 82% for drug-free counseling.³ Thus Hawaii's record seems to be well above average.

Only 64 subjects (or 25%) reported previous involvement with a drug treatment program, and only 14 subjects (6%) had been referred to DASH from other drug programs. In turn, DASH referred only 24 subjects (9%) to other drug programs, and yet more than 50% reapplied for treatment at DASH. These figures support the impression that, for the most part, Hawaii's drug treatment programs tend to operate quite independently of each other.

In conclusion, heroin addiction remains a major problem in Hawaii. The large number of new applicants seen at DASH during the period of study is consistent with our observations that heroin addicts are frequently seen in emergency rooms and general hospitals with a variety of complications related to their drug problem. Experiences of drug programs throughout the

mainland have generally proven that the problem of heroin addiction is a complex, multi-faceted one that is very difficult to treat. Various approaches to treatment have been developed. These have included methadone maintenance, therapeutic communities and narcotic antagonists. None has come close to solving a community's addiction problem. Often the different treatment programs tend to compete with each other rather than cooperate.

One approach which has proved more successful than others has been the multi-modality treatment approach. This allows selection from a variety of alternatives the treatment approach best suited to a given addict. This approach requires close cooperation among different types of programs, and constant evaluation and feedback by professionals who coordinate the different modalities. An ideal multi-modality program would involve several elements such as the following:

- 1) A drug-free program, a methadone maintenance program and several therapeutic community programs, each oriented toward different needs of addicts.
- 2) A central screening-detox unit to evaluate new intakes and refer to the appropriate treatment modality. It would also evaluate potential transfer from one treatment unit to another.
- 3) A central administration, with a physician-director who would monitor and coordinate the clinical activities of all the units, and broaden the skills of the treating staff through continuing education and feedback.
- 4) Close liaison with defense attorneys, prosecuting attorneys, judges, and probation officers. Legal pressure is crucial in keeping an addict in treatment, and results correlate with duration of treatment.³
- 5) A vocation training section with programs specific for the needs of addicts.
- 6) A community education section to teach school teachers, police, judges, lawyers, physicians, and others about drug abuse.
- 7) A research and evaluation section to constantly monitor and feed back the results of the programs and examine such issues as ethnic differences.

Unfortunately, Hawaii does not have such a multi-modality treatment program. This lack, in combination with an apparent influx of drug abusers from the mainland, tends to keep the population of addicts in Hawaii at high levels.

REFERENCES

1. Jose GW, Singh BK, Finklea D, et al: Community Factors, Racial Composition of Drug Abuse Treatment Programs and Outcomes. *Services Research Report*, DHEW Publication No.78-573, National Institute on Drug Abuse, Rockville, Maryland, 1977.
2. Streltzer J: Psychiatric Emergencies in Travelers to Ha-

waii: *Comprehensive Psychiatry*, 20:463-468, 1979.

3. Simpson DD: The Relation of Time Spent in Drug Abuse Treatment to Post-treatment Outcome. *Am J Psychiat*, 136:1449-1453, 1979.

Eosinophilic Meningitis Due to *Angiostrongylus cantonesis* in American Samoa

MARK J. BECK, M.D.*; TIMOTHY M. CARDINA, M.D.** and JOSEPH E. ALICATA, Ph.D.***, Honolulu

One of the important developments in tropical medicine during the past 20 years has been the recognition of the rat lungworm (*Angiostrongylus cantonesis*) as the primary etiological agent of eosinophilic meningitis in the Pacific and Southeast Asia^{1,2}. The disease has been previously reported from the Caroline Islands, Cook Islands, Hawaiian Islands, New Caledonia, New Hebrides, Philippine Islands, Society Islands, Sumatra, Taiwan, Thailand, and Vietnam.¹ The manifestations of this syndrome often include headache, stiffness of the neck, cutaneous paresthesia in various areas of the body, and eosinophilia in the cerebrospinal fluid.³

The first case of eosinophilic meningitis to occur in American Samoa was observed in Pago Pago during August, 1979. Within the next 3 months, 8 additional cases were diagnosed (Table 1). Of 4 rats trapped in Pago Pago, 3 showed adult lungworms which were identified as *A. cantonesis*. These findings came as a surprise, as this parasite had not been found previously in Samoa. Alicata and McCarthy (1964)⁴ found no lungworms in 98 rats trapped near Apia, Western Samoa; similarly, Wallace and Rosen (1965)⁵ reported absence of lungworms in 198 rats trapped in Tutuila, American Samoa. The above leads to the belief that the rat lungworm was introduced to Samoa in recent years, most likely by the giant African snail (*Achatina fulica*). According to a personal communication from Dr. Harry K. Nakao, formerly with the Hawaii Agriculture Department, the giant African snail was found to be well established in parts of Tutuila by June, 1977. This led him to speculate that it had probably been introduced to the island at least 2 years previously (1975). It has

also been theorized that this snail was instrumental in spreading the rat lungworm to various Pacific Islands along with its eastern dispersal route.⁶ The present findings lend further support to this theory.

Human infection with eosinophilic meningitis is most frequently acquired as a result of ingesting raw or improperly cooked snails or freshwater prawns which serve as intermediate and paratenic hosts, respectively, of the rat lungworm. Of the 9 cases reported below, 5 gave a history of having eaten from 6 to 20 prawns each.

Summary of Cases

A total of 9 patients, 8 male and 1 female, ranging in age from 10 to 54 years, were hospitalized in American Samoa between 8/10/79 and 11/29/79 with a diagnosis of eosinophilic meningitis. In 5 of the 9 cases, there was a history of ingesting raw freshwater prawns between 4 and 16 days prior to the onset of symptoms. Four of these 5 (Patients No. 3, 4, 5, 7) shared a common meal of raw prawns, the 5th (Patient 2) being from a separate source. Patients 3, 4, and 5 had consumed raw prawns together on a previous occasion and nearly identical symptoms had developed 2 weeks after that ingestion; however, the diagnosis of eosinophilic meningitis was not made at that time.

Symptoms: Headache was present in all patients (Table 1), and was usually the first symptom. Six patients noted neck stiffness for several days while they had headaches, but none at the time of examination. In 7 patients, nausea and vomiting developed several days after the onset of headache and lasted 3 to 4 days. Cutaneous paresthesia occurred in 4 patients, the onset ranging from 2 days preceding to 5 days following the headache. This was the most persistent

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TABLE 1.

Patient	1	2	3	4	5	6	7	8	9
Admitted to hospital	8/10/79	10/21/79	11/8/79	11/11/79	11/13/79	11/13/79	11/21/79	11/25/79	11/29/79
Sex and age	F 18	M 27	M 20	M 13	M 54	M 10	M 14	M 30	M 13
Ingestion of prawns	—	10/13/79	10/21/79	10/21/79	10/21/79	—	10/21/79	—	—
Incubation period	—	13d	16d	14d	4d	—	14d	—	—
Symptoms ¹	H,NV,L	P,H,S,L	H,S,NV,P	H,P,S,NV	H,S,P,L	H,F,NV	H,S,NV	H,VN	H,F,NV,S
Neurologic findings	Nystagmus	Hyper-reflexia (L) arm Hyperesthesia	Bell's palsy	Hyperesthesia	Hyper-reflexia (R) knee Hyperesthesia	—	—	—	—
Peripheral Blood									
WBC/cmm	11,500	11,800	11,700	11,200	12,100	12,700	20,000	6,800	11,300
% Eosinophils	3	45	10	40	31	10	47	18	16
CSF WBC/cmm	900	1,500	495	846	1,500	1,520	341	447	300
% Eosinophils	85	90	70	93	90	94	16	90	70
% Lymphocytes	15	1	10	7	9	6	34	10	22
% Segmented	0	9	20	0	1	0	50	0	8
Glucose	48	48	52	55	59	49	48	56	—
Protein	42	53	32	26	21	17	30	—	—
Serologic test titers for <i>Angiostrongylus</i>	(a) ² 1:512 (b) ³ 1:64	—	1:256 1:128	1:256 1:128	1:256 1:64	1:1024 1:512	1:2048 1:1024	1:512 1:256	1:256 1:128

¹Symptoms listed in order of occurrence.

Key: NV = Nausea and/or vomiting

L = Lethargy

H = Headache

S = Stiff Neck

P = Paresthesias

F = Fever

²IHA test (titer 1:128 or greater considered positive).

³ELISA test (titer 1:64 or greater considered positive).

symptom, lasting from 2 to 4 weeks. Two patients noted blurred vision and 1 noted diplopia, but these were transient symptoms. Only the 2 youngest patients complained of fever on the day of onset of headache, but their temperatures were not measured on those days.

Signs: Patients presented to the hospital between 1 and 18 days after the onset of symptoms. Four patients had normal physical examinations including careful neurologic examinations. In 3 patients, regions of cutaneous hyperesthesia to light touch were consistently present on repeated examinations, and 2 of these patients had abnormal tendon reflexes. Patient 2 had hyperesthesia involving the right lower leg and left upper arm and shoulder, and also had hyperreflexia of the left biceps, triceps, brachioradialis, pectoralis, finger flexors, and a positive Hoffman's reflex on the left. Patient 5 had hyperesthesia of the right shoulder and foot medially, and also had a decreased knee jerk reflex on the right, which normalized in 3 weeks.

Patient 1 had sustained bi-directional horizontal nystagmus which resolved after 3 weeks. Patient 3 developed a Bell's palsy on the side.

None of the patients had fever or signs of meningeal irritation, and alteration in sensorium was limited to mild lethargy in 3 cases.

47%, with leukocyte counts between 6,800 to 20,000 per cmm. (Table 1). Spinal fluid was cloudy in all instances and showed pleocytosis, with leukocyte counts between 300 and 1500 per cmm. Eosinophils comprised 16% to 94% of the cells present. Patient 3 (who had ingested raw prawns on a previous occasion) had 2 CSF examinations; the first was 2 weeks after the onset of the first course of symptoms and was reported to contain 108 leukocytes per cmm., with 92% lymphocytes and 8% segmented neutrophils. After his second ingestion and subsequent course of symptoms, a repeat CSF examination showed 495 leukocytes per cmm. with 70% eosinophils and 10% lymphocytes. In retrospect, it is possible that on the slide from his first CSF, which inadvertently was not saved for review, suboptimal CSF staining technique and examination may have led to the misinterpretation of eosinophils as lymphocytes.

The sera of 8 of the 9 cases of angiostrongyliasis were tested by an indirect hemagglutination (IHA) and ELISA technique using crude extracts of adult *Angiostrongylus* worms (Table 1). All sera were positive and, therefore, of high diagnostic significance. The tests were made by Miss Dorothy Allain, Research Microbiologist, Parasitology Division, Center for Disease Control, Atlanta, Georgia.

Laboratory Data

In 8 of 9 cases, eosinophilia was present on peripheral blood smear, and ranged from 10% to

Treatment and Follow-Up

All patients received symptomatic treatment for headache with either acetaminophen or as-

pirin 325 to 650 mg. p.o.q. 4h. In addition, several patients required codeine phosphate 30 to 60 mg. q. 4h. for adequate control of pain due to headaches or paresthesias.

Corticosteroids were not used. Several patients reported improvement in their headaches within 24 hours after the spinal tap was performed, but this was not a consistent finding, and all patients were receiving analgesics at those times.

Headaches lasted from several days to 3 weeks after admission. Patients 2 and 5, who had paresthesias associated with objective neurologic findings, both noted a gradual decrease in sensory symptoms over 2 weeks and developed pruritis in the affected areas 3 weeks after the onset of paresthesias.

Patients became asymptomatic within 3 weeks of admission, with the exception of patients 2 and 5, whose symptoms lasted 6 weeks. Only patient 4 required a second hospitalization because of persistent vomiting which was controlled with parenteral Compazine.

All of the patients recovered and were asymptomatic, without any residual neurologic deficits at 6 weeks after hospitalization.

Distribution and Incidence of the Parasite

Since eosinophilic meningitis in the Pacific is known to be largely caused by the rat lungworm *A. cantonensis*, a limited survey was carried out in American Samoa to determine the incidence of the adult parasite among wild rats, and of its infective larval stage among terrestrial mollusks and freshwater prawns. The rats were examined in Samoa, but the mollusks and freshwater prawns were submitted and examined for infective third-stage larvae at the University of Hawaii, Honolulu.

Survey of rats: Of a total of 38 rats (mostly trapped in the Tafuna District), 31 (81.5%) harbored adult lungworms (*A. cantonensis*). Of these rats 33 were *Rattus norvegicus* (30 infected), and 5 were *R. rattus* (1 infected).

Survey of terrestrial mollusks: Of 10 giant African snails (*A. fulica*) and 1 slug (*Vaginulus plebeius*) collected in Tutuila, all were found to harbor several hundred third-stage metastrongylid larvae. The larvae were recovered by coarsely grinding the slug and each shelled snail in a small meat-grinder and artificially digesting each of them in pepsin-HCl solution⁸. Identification of the larvae was carried out by feeding about 100 of the larvae recovered to each of 3 half-grown laboratory-bred albino rats. Two of the rats received the larvae from the snails and 1 rat received the larvae from the slug. All 3 rats were killed 45 days following experimental infection and were found to harbor several adult *A. cantonensis* in the pulmonary artery. Two other albino rats of the same group, kept as control, were found negative for lungworms.

Survey of freshwater prawns: Of a total of 42 prawns (*Macrobrachium lar*), (caught in a stream in the Leone District, and measuring 9 cm. or more in length), 18 (42.8%) showed infective metastrongylid larvae. These larvae were recovered from the stomach of each prawn by the use of the Baermann technique⁷. The number of larvae recovered from each prawn ranged from 2 to about 150. To determine their identity, about 100 of these larvae were fed by stomach-tube to each of 4 half-grown laboratory-bred albino rats. When these rats were killed 45 days after infection, all were found to harbor mature *A. cantonensis* in the pulmonary artery. Four albino rats, kept as controls, were found negative for lungworms.

Discussion

It is evident that angiostrongyliasis cantonensis is a new parasitic disease of man in Samoa. It appears to be largely acquired as a result of digesting infected raw freshwater prawns. The present study indicates that the causative parasite is well established among the rat population as well as among the various vectors, including at least terrestrial snails, slugs, and freshwater prawns. Although the parasite is known only from the Island of Tutuila, it is possible that it may be introduced to the rest of the Samoan Archipelago unless precautions are taken against the spread of the infected rats or mollusks.

Preventive measures against human angiostrongyliasis in Samoa, as in other endemic areas, should include at least the following:

1. Avoid eating raw mollusks (snails or slugs) or crustaceans (freshwater prawns or crabs), whether alone or mixed with other food; proper cooking or freezing (24 hours at -15°C) have been found effective in destroying the larvae of the rat lungworm⁹.
2. Green vegetables intended to be eaten raw, or ripe fruits fallen to the ground, should be inspected for mollusks and washed in running water before being eaten.
3. Young children should be prevented from playing with or placing snails or slugs in their mouth¹⁰.
4. Rat and mollusk control within an endemic area should assist in reducing the spread and source of human infection.

Summary

For the first time, during the latter part of 1979, 9 cases of eosinophilic meningitis were diagnosed in Tutuila, American Samoa. Five of the patients gave a history of having ingested raw freshwater prawns.

Of a total of 38 rats trapped in Tutuila, 31 (81.5%) harbored adult lungworms, *Angiostron-*

gylus cantonensis. Infective third-stage larvae of this parasite were found in 18 out of 42 (42.8%) local freshwater prawns (*Macrobrachium lar*) examined, and in all of 10 giant African snail (*Achatina fulica*) and 1 slug (*Vaginulus plebeius*) examined. The identity of the larvae was ascertained by animal feeding experiments.

The rat lungworm appears to have been introduced to American Samoa in recent years, most likely by the giant African snail, which is estimated to have been introduced in 1975.

Preventive measures against human infection include at least proper cooking of freshwater prawns or mollusks, and washing of vegetables intended to be eaten raw. Adequate control of rodents and mollusks in an endemic area should assist in reducing the spread and source of human infection.

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Mary Serdula, Center for Disease Control, U.S. Public Health Service, Honolulu; Dr. Robert Tesch, Pacific Research Institute, Honolulu, and Dr. Robert MacLean, Center for Disease Control, U.S. Public Health Service, Fort Collins, Colorado. Miss Dorothy Allain, Center for Disease Control, U.S. Public Health Service, Atlanta, Georgia, conducted the serologic tests for *Angiostrongylus* for 8 of the patients. Dr. Richard W. Stanley, Department of Animal Sciences, University of Hawaii, made available laboratory space and equipment. Dr. Robert Van Reen, Department of Food and Nutritional Sciences, University of Hawaii, supplied the necessary laboratory rodents. Dr. J. Ralph Lichtenfels, U.S. Department of Agriculture, Beltsville, Maryland, assisted in confirming the identity of the rat lungworms from Samoa. Dr. D. F. B. Char, Student Health Service, University of Hawaii, and Dr. Jane Fyrberg reviewed and made comments on the draft of this paper. Lastly, thanks to the Samoan patients and their families who contributed information and specimens for this study.

REFERENCES

1. Alicata JE, Jindrak K: Angiostrongylosis in the Pacific and South-east Asia, Charles C Thomas, Springfield, Ill. 1970.
2. Kuberski F: Eosinophils in the cerebrospinal fluid. *Ann Int Med* 91:70-75, 1979.
3. Jindrak K: Angiostrongyliasis cantonensis (Eosinophilic Meningitis, Alicata's Disease). In: Hornbrook RW (ed.) *Topics on Tropical Neurology*, F A Davis, Philadelphia, Pa. 1975.
4. Alicata JE, McCarthy DD: On the incidence and distribution of the rat lungworm *Angiostrongylus cantonensis* in the Cook Islands, with observations made in New Zealand and Western Samoa. *Canad J Zool* 42:605-611, 1964.
5. Wallace GD, Rosen L: Studies on eosinophilic meningitis 1. Observations on the geographic distribution of *Angiostrongylus cantonensis* in the Pacific area and its prevalence in wild rats. *Am J Epidemiol* 81:52-62, 1965.
6. Alicata JE: The presence of *Angiostrongylus cantonensis* in the islands of the Indian Ocean and probable role of the giant African snail, *Achatina fulica* in dispersal of the parasite to the Pacific Islands. *Canad J Zool* 44:1041-1049, 1966.
7. Faust EC, Beaver PC, Young RC: Animal Agents and Vectors of Human Disease, Lea & Febiger, Philadelphia, Pa. 1968.
8. Chen TC, Alicata JE: On the modes of infection of *Achatina fulica* by the larvae of *Angiostrongylus cantonensis*. *Malacol* 2:267-274, 1965.
9. Alicata JE: Effects of freezing and boiling on the infectivity of the third-stage larvae of *Angiostrongylus cantonensis* present in land snails and freshwater prawns. *J. Parasit* 53:1064-1066, 1967.
10. Char DFB, Rosen L: Eosinophilic meningitis among children in Hawaii. *J Pediatr* 70:28-35, 1967.



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Who Needs A Union?

The gentlemen of the British Medical Association (BMA) resisted the concept of unionism under the National Health Service (NHS). For two decades, England's physicians splintered into warring factions under the NHS dictatorship. After 25 years of subjugation, G.P.'s were paid \$8 for night housecalls (versus \$48 for veterinarians) while their office visit allowance was 60¢ (versus electricians' \$6.65 for the first 15 minutes). Finally, in ignominy and desperation, the BMA became a trade union. Alas, British physicians remain subservient and impoverished, the brain drain continues, and there's a waiting list of 700,000 for hospital beds. Meanwhile in Belgium, physicians organized a strong union before medical care was socialized; they vigorously resisted fragmentation, and fought along a united front. Today, Belgium's physicians remain in a unique and enviable situation, completely in control of medical care.

The lesson to be learned from other nations is this: the earlier in the evolution of socialized medicine that physicians organized to protect their interests, the better they have fared.

In our country, pressures on physicians continue to mount. We have to cope with the insurance industry, the hospital industry, and the federal government, all of whom are trying to interpose themselves between us and our patients. These are social and group forces, concerned with the greatest good for the greatest number, while medicine remains a personal service, concerned with maximum benefit for the individual. Thus an adversary relationship must develop between conscientious physicians and these agencies: we cannot serve two masters, and our patients come first.

Meanwhile, technological advances and consumer demands have exploded the price of health care; it becomes increasingly necessary for individuals to protect themselves through insur-

ance or government programs. As third-parties have borne larger shares of the cost, the patient proves rare, indeed, who pays his doctor-bills unaided. Since we receive an increasing percentage of our income from these third-parties, while following their orders and performing their tasks, we physicians now resemble labor, far more than we resemble management.

When costs mount and government subsidies and entitlements increase, fiscal controls must follow: enter Utilization Review, HSAs, PSRO, SHPDA, CON, etc. As these controls are assembled, our profession becomes selectively regimented and socialized. But physicians are powerless to individually resist DSSH, HHS (*néé* HEW), and the FDA; our very individualism renders us more vulnerable. Our national and local medical societies and specialty organizations are neither legally nor philosophically constituted to battle these forces which strive, ultimately, to control financing and delivery of medical care.

Meanwhile, up there in the stratosphere floats the untouchable Air Line Pilots' Association (ALPA). This elite union has the clout and talent to secure industrywide safety measures for passengers, along with \$123,000 salaries (for an 18-hour week) for Captains. ALPA burnishes the pilots' image, while fattening their fringe benefits, all without a hint of impropriety or a whisper of negative publicity.

On the assumption that physicians may be at least as useful to society as pilots, the Union of American Physicians and Dentists was formed in 1972. Patterned on ALPA, this fledgling has grown to 9,600 members in California, over 28,000 nationwide. The UAP-D has an impressive record of collective bargaining for hospital-based and HMO physicians, recovery of disputed claims for private physicians, and improved patient care. By its firm but reasoned stance with hospitals, fiscal intermediaries, and state and federal government, the Union has achieved respect and attention without ever having to deny necessary medical care. Representing one-third of California's practicing physicians, the Union functions smoothly alongside the California Medical Association in an atmosphere of mutual respect: CMA deals with professional and scientific affairs, while the UAP-D provides socioeconomic leadership.

Perhaps there's something to this: last month, the Canadian Medical Association, powerless to cope with its government's latest harassment, began investigating trade unionism. Whether Canadians, like the British, will be too late with too little, remains to be seen. Here at home, there may yet be time. As Sanford Marcus, M.D., President of the UAP-D, told HMA members several years ago, "Someday you *will* form a Union. Either now, while you still have a little bargaining power left, or later, when we physi-

cians have been destroyed as an economic force."

Judging by the drift of things, circumstances are not improving for our patients or ourselves. Perhaps Marcus has an idea whose time has come.

JMC

Leisure Crisis

According to reliable handwringers, our country suffers from a Health Care Cost Crisis of grave proportions. Families stagger beneath their health insurance burden, Medicare and Medicaid bankrupt the federal treasury, and spending for all forms of health care has reached the "crisis level" of 9% of our gross national product (GNP).

As if that weren't bad enough, Americans struggle beneath an increasingly burdensome Leisure Care Cost Crisis. Spending for all forms of leisure activities has now reached a crushing 13.4% of the GNP, and is rising at an alarming rate.

Perhaps it's not too soon to consider Federal Regulation, including Certificates of Need, to ease this Leisure Crisis before the burden becomes insurmountable; soon it may be too late!

JMC

Osteoporosis Project Evaluation and Treatment

Volunteers are being sought to participate in an osteoporosis project under the Pacific Health Research Institute, funded by the Upjohn Company. The purpose of this study is to precisely define the presence and severity of osteoporosis and determine whether a chemical relative of Vitamin D, hydroxycholecalciferol, can delay or prevent the progression of "postmenopausal" osteoporosis. Osteoporosis literally means porous bone, a disorder in which not enough bone is present to maintain skeletal strength, with the result that fractures may occur. It is very common in women after menopause.

As required by the FDA, a bone mineral analysis by osteodensitometry is done on all participants. The osteodensitometer passes a narrow beam of gamma rays from a ^{125}I source through the radius, and a computer calculates the amount of bone mineral content. Up to now we have depended primarily on clinical evaluation and x-rays which have been quite unreliable methods of detecting early cases of osteoporosis. The patient has no discomfort. The amount of radiation involved is minuscule. About 50 percent of women over age 55 and 30 percent of men over 60, as well as almost all patients with chronic kidney disease undergoing long-term renal dialysis, have some degree of osteoporosis, which often contributes to spine and hip fractures and skeletal deformities.

This capability of diagnosing osteoporosis at an early stage should make it possible to determine whether diet, medication, or exercise arrests or reverses the course of osteoporosis.

Sixty symptomatic and two hundred asymptomatic women are needed for the project. We are particularly in need of symptomatic volunteers. These volunteers may be any age provided that they are entered into the study at least one year following their natural menopause.

All subjects must have a history of back pain and must also have a vertebral score of at least 4 to participate. The vertebral score is determined via examination of the patient's lateral-view spinal x-ray as follows: normal vertebrae score 0; wedged vertebrae score 1; and all crushed vertebrae score 3.

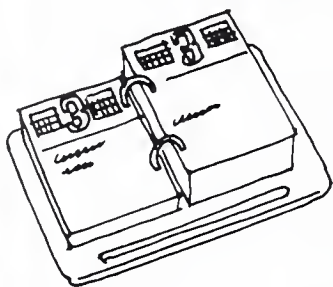
Subjects fitting any of the following criteria *cannot* participate in the study:

1. Women with liver disease, kidney disease, thyroid disease, diabetes, epilepsy, malabsorption syndromes, or diagnosed malignancies.
2. Women receiving estrogen preparations, gold, systemic corticosteroids, anti-convulsant therapy, fluoride, major tranquilizers, or cytotoxic agents. Patients requiring these medications during the course of the treatment must be dropped from the study.
3. Women with a history of hypercalcemia (>10.5 mg/dl) or who have been taking supplemental vitamin D (>400 units/day).
4. Women with an allergy to corn or corn products.

The Osteoporosis Project is located at Straub Clinic & Hospital under the direction of Dr. Fred Gilbert. Mary Hoffmeier, R.N., serves as project coordinator. For further information, please call 521-8269 or 523-2311 ext. 227.



"That's very generous of you, Mr. Sykes — but at the moment we just do not have a patient who could use your wife's tongue."



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani 1 Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

- B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. H1 Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1.
 - A. **10/20/80**—Anals of Emerg. Med. (Aug 1980) 10-12 noon-Abstracts in ER Med (July 1980)
 - B. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 - C. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.

2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Visiting Professor Programs
2. Department of Ophthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
3. G. I. Conference, Third Tuesday, 8:00-9:00 a.m.
4. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
6. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, Third Thursday, 1:00-2:00 p.m.
8. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.

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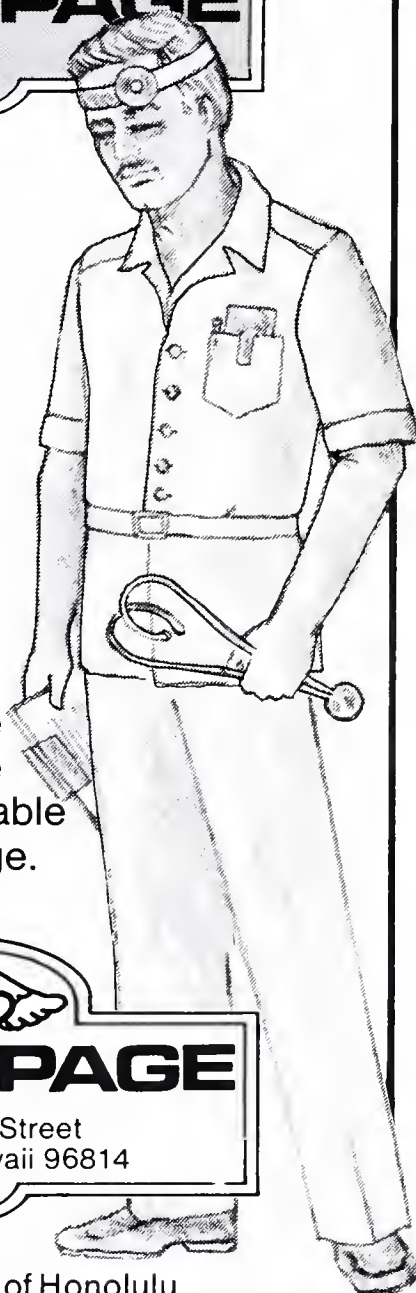
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4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

Nov. 3-5, 1980

Recertification Course for ACLS Providers-HI Heart Assoc. CPR Cntr. of HI, 1301 Punchbowl St., S 203, Honolulu. 8 hrs. Cat. I; Fee \$150. Contact: Skip Kirkwood, Prog. Dir. (808) 531-0174.

Nov. 13, 15, 1980

PAT-Phys/Admins/Trustee Conf. on Quality Assurance. InterQual, 740 N. Rush St., Chgo, IL 60611. Held at Royal Lahaina Resort, Maui. 14 hours.

Nov. 22, 29, 1980

Financial Planning for Phys. U of Wash CME, SC-50 Seattle, Wash. 98195. w/U of HI. Wailea Beach Htl., Maui. 7 days, 49 hrs.

Nov. 23, 30, 1980

New Directions in Psychiatry, U of Wash., John N. Lein, M.D., Div. of CME, Box SC-50, Seattle, Wash, 98195. Co-Spons. J. A. Burns Schl. of Med. Held at Ilikai Htl., Honolulu.

Dec. 1, 5, 1980

AMEDD Child Psychiatry Symp. TAMC/US Dept. of Army Off. Surg. Gen. Held TAMC, Honolulu 96859. 5 days, 35 hrs.

Dec. 3, 1980

Advanced Workshop for Laryngectomy Rehabilitation. American Cancer Society-HI Div. Held: Conf. Rm B-2 Tripler AMC, Hawaii. 8:00a.m.-4:45p.m. Fee \$10.00 7 hrs. Cat. I. Advance Registration required-deadline Dec. 1. Contact: Donna Farr, ACS, (808) 531-1662.

Dec. 4-6, 1980

"Gynecological Surgery," sponsored by the American College of OB/GYN. 16 hrs. Cat. I. To be held at Hyatt Regency, Waikiki.

Dec. 11-14, 1980

Am. Med. Joggers Assoc. Contact: Hugh S. Amcs, Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.

Dec. 14-20, 1980

Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

Jan. 10, 17, 1981

Perinatal Med. U of So. CA Schl of Med, 2025 Zonal Ave. LA, CA. Held at Royal Lahaina Htl, Maui. 4 days, 24 hrs.

Jan. 15, 22, 1981

Med. Staff of Iowa Lutheran Hosp-Postgrad Conf. Iowa Lutheran Hosp, De Halder, Exec Sectry, U at Penn Ave., Des Moines, IA 50316. Held: Kauai Surf Htl, Kauai. 6 days, 24 hrs.

Jan. 18, 25, 1981

Sixth Ann Hawaii Hosp Med Staff Conf., Estes Park Inst. w/Queen's Med Cntr. Kauai Surf Htl, Kauai. Estes Park Inst., Box 400, Englewood, CO 80151. 5 days, 32 hrs.

Jan. 24, 31, 1981

Internatl Diagnostic Radiology. U of CA, Extended Prgms in Med. Ed., Dept. of Radiology, Rm M 396, 3rd & Parnassus Ave., San Fran, CA 94143. Held on island of Hawaii. 5 days, 40 hrs.

Jan. 26, 29, 1981

Adv. Sems. for Phys. Administrators & Trustees. Estes Park Inst., Box 400, Englewood, CO 80151. Held: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 15 hrs.

Feb. 1, 8, 1981

Clinical Allergy. J. A. Burns Schl of Med., U of H. Honolulu, HI. Held: Hyatt Regency, Maui. Contact: Dee Chang, (808) 947-8573 or 948-7457.

Feb. 3, 5, 1981

Office Dermatology for the Primary Care Physician. J. A. Burns Schl of Med., 1960 E-West Road, Honolulu, 96822. Co-sponsor:

Hi Chapt. AAFP. Held at Kahala Hilton Htl, Honolulu. 3 days, 12 hrs.

Feb. 5, 6, 1981 Third Symposium on Diabetes in Asia and Oceania. J. A. Burns Schl of Med. Honolulu. Held: Kobe Univ. School of Medicine, Honolulu.

Feb. 16, 20, 1981 Symp on Preleukemic & Acute Nonlymphocytic Leukemia. J. A. Burns Schl of Med. Held: Hyatt Regency, Honolulu. 5 days, 25 hrs.

Feb. 21, 28, 1981 Metabolism & Endocrinology. U of Wash CME SC-50, Seattle 98195. Co-sponsor-Wash State Med. Assn. Held: Kona Surf, Kona, HI. 7 days, 49 hrs.

Feb. 23, 25, 1981 Postgraduate Course in Vascular Surgery. Am Col of Surgeons/co-sponsor J. A. Burns Schl of Med., U of H. Held at Hawaiian Regent Hotel, Honolulu.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



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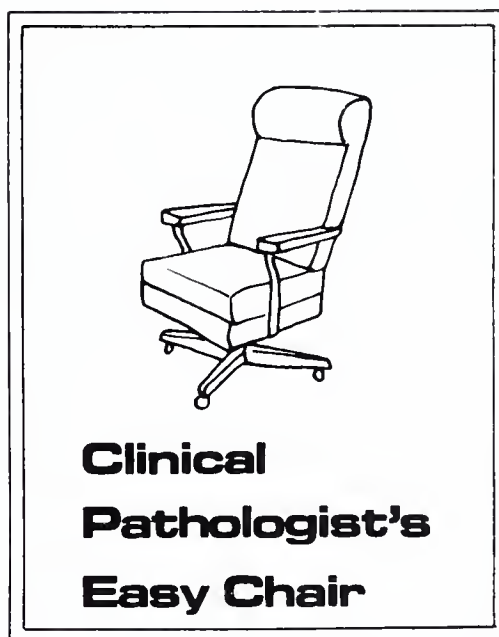
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FAMILY PRACTICE



FRANCIS FUKUNAGA, M.D.

Acid Phosphatase

Carcinoma of the prostate gland is the third leading cause of cancer death in American men; there are about 42,000 new cases in the United States each year.^{1,2} Unfortunately, only about 10% of these new cancers are early Stage I and II lesions. In 1938, the Gutmans reported that serum acid phosphatase activity was elevated in patients with metastatic prostatic carcinoma.³ Approximately 70 to 90% of prostatic carcinomas with bone metastases have elevated serum acid phosphatase activity, but only rare cases of early localized tumors show this change; ie, acid phos-

phatase activity is rarely elevated at a stage where early diagnosis and treatment would be most effective.² Enzyme evaluation of prostate carcinoma still cannot compare with a properly performed rectal examination followed by a biopsy of suspicious areas.

Acid phosphatase is an enzyme that hydrolyzes phosphate esters in an acid environment. It is found in the prostate gland, erythrocytes, liver, bone, kidney, spleen, urine and platelets. Serum acid phosphatase is a mixture of phosphatases derived from various tissues and most of the serum activity is from the platelets, released during the clotting process and only a small amount comes from the prostate gland. The predominant acid phosphatase in normal serum is resistant to L-tartrate, while prostatic acid phosphatase is L-tartrate-labile. Other sources of tartrate-labile acid phosphatase include the lungs, bone, intestines, pancreas, spleen and bone marrow. Granulocytes, lymphocytes and plasma cells have tartrate-labile acid phosphatase, while hairy cell leukemic cells have the tartrate-resistant enzyme. There is increased acid phosphatase activity in chronic granulocytic leukemia.⁴ It is also elevated in bone resorption due to increased osteoclastic activity.

Serum acid phosphatase is stable at -20°C for 2 to 3 months and at 10°C for 2 weeks, but the enzyme activity decreases significantly at room temperature within 1 to 2 hours. This decrease is due to the pH elevation caused by the loss of carbon dioxide. This loss can be minimized by storage of the serum in tightly stoppered containers, by not separating the clot or by

buffering the serum at pH 6.2 to 6.6.

Prostatic acid phosphatase is found in the glandular epithelium and the lumens of ducts. There are at least 2 prostatic isoenzymes, and enzyme activity increases with age. Serum acid phosphatase activity shows a circadian rhythm but it does not peak at the same time each day; therefore, a single test is not sufficient to exclude prostatic carcinoma. When elevated, serial testing is a useful marker for monitoring the effectiveness of therapy. There is no correlation between acid phosphatase activity and the amount and location of metastases. A significant number (14%) of Stage IV tumors show no apparent increase of serum acid phosphatase activity, even with extensive metastases.⁵ There is usually less enzyme activity in poorly differentiated cancers. True positive increases of acid phosphatase other than with carcinomas include infarction of the prostate gland, prostatic massage, urologic instrumentation and prostate surgery. False positives include contamination with acid phosphatase from other sources, such as bone disorders including Paget's disease and metastatic carcinomas to bone, hepatobiliary diseases such as viral hepatitis, cirrhosis and extrahepatic biliary obstruction, Gaucher's disease, carcinoma of the breast and colon. Bone marrow acid phosphatase is positive in 60% of the aspirated material due to the unavoidable hemolysis.⁶

Thymolphthalein monophosphate is considered the most specific substrate for the prostatic acid phosphatase because it is the least sensitive to nonprostatic acid phosphatase.⁷ The Sigma method using p-nitrophenyl phosphate is now considered an outmoded procedure.⁵ Methods for separation of the acid phosphatase isoenzymes are not specific for the prostatic enzyme. The most widely used inhibitor of the prostatic acid phosphatase, L-tartrate, also inhibits other acid phosphatases.⁴ The total serum acid phosphatase was shown to be a more sensitive test than the tartrate-labile prostatic phosphatase in a study of 185 carcinomas and 141 benign hyperplasia.⁸ The new immunoassays are more sensitive and specific than the routine chemical assays, but the sensitivity for Stage I carcinoma is still low, about 10% by radioimmunoassay while the Thymolphthalein method is about 5% sensitive. The sensitivity of the Thymolphthalein method is 0.11 IU/L and the upper limits of normal is 0.8 IU/L.

REFERENCES

1. Silverberg E. Cancer Statistics, 1980, *Ca-a cancer journal for Clinicians*, 30:23-38, 1980.
2. Klein, LA. Prostatic carcinoma, *New England J Med*, 300:824-833, 1979.
3. Gutman AB, Gutman EB. An acid phosphatase occurring in the serum of patients with metastasizing carcinoma of the prostate gland, *J Clin Invest*, 17:473-478, 1938.
4. Yam LT. Clinical significance of the human acid phosphatases, *Amer J Med*, 56:604-616, 1974.
5. Griffiths JC. Prostate-specific acid phosphatase: re-evaluation of radioimmunoassay in diagnosing prostatic disease, *Clin Chem*, 26:433-436, 1980.
6. Pontes JE, et al: Bone marrow acid phosphatase in staging prostate cancer, How reliable is it? *J Urol*, 119:772-776, 1978.
7. Roy AV, et al: Sodium Thymolphthalein monophosphate, a new acid phosphatase substrate with greater specificity for the prostate enzyme in serum *Clin Chem*, 17:1903-1102, 1971.
8. Murphy GP, et al: Comparison of total and prostatic fraction serum acid phosphatase levels in patients with differentiated and undifferentiated prostatic carcinoma, *Cancer*, 23:1309-1314, 1969.


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DON AND MARLIES FARRELL

Our belated congratulations to **Jim and Margaret Tsuji** on the birth of their second child, a son named Franklin, on August 12. The following members were reelected for 1981: to practicing affiliate: **Baron K.F. Ching** and **Carlos Lam**. To inactive status: **Paul Liljestrand**, **Satoru Matsuyama**, **Ernesto Santos**, **Arthur Vasconcellos**. One member, **James F. Fleming**, was elected to Life membership. He has been with the Academy since 1952 and a member of our chapter since 1961 when he came from California to practice on Maui. Best wishes, Dr. Fleming.

President **Pat Dietrich** appointed two deputy education chairmen for Kauai. At Wilcox Hospital **John Newman** and at Veteran's Memorial Hospital **Mark Wentworth** will submit programs for AAFP approval. This should help our members on Kauai to obtain "P" credit without having to travel long distances. Hopefully we will be able to do the same on other neighbor islands in the near future.

You will be happy to hear that the Executive Council voted to keep dues at their "rock bottom" level for another year, however we expect inflation to catch up with us sooner or later.

Plans are being finalized for a one day scientific seminar in conjunction with our **annual meeting**, January 24, 1981 at the Ilikai Hotel. Several excellent speakers have already been lined up and mailings with detailed information should go out in November. In connection with the Annual Meeting, **Pat Dietrich** is asking for nominations from the membership. All offices as well as several councillor positions are up for grabs and some new blood is needed. Please call **Marlies Farrell** at 235-3115 with your suggestions.

The next **dinner meeting** promises to be a very special one. **Bob and Dolores Todd** will be the hosts. They live in a 1914 vintage home at Fort Kam and invite everyone to come early on November 8, to do some sightseeing and enjoy the sunset over Pearl Harbor. The program too is of a special nature, offering a possible 12 hrs. "P" credit. Dr. George W. Manning, Psychiatrist, will moderate a group discussion on "Depression Today" after the presentation of three films on the subject. Monographs and post tests to be completed at home add up to a lot of credit hrs. Merrell Laboratories are sponsoring the program and are also donating \$100.00 towards pupus for the evening!

A few **CME notes** on upcoming programs: February '81 offers several events of importance.

Feb. 1-8 at the Hyatt Regency, Maui: University of Hawaii at Manoa Postgraduate Course in Clinical Allergy.

Feb. 22-28 at the Ilikai in Honolulu: Practical Neurology for Primary Physicians, sponsored by University of Washington Medical School.

Feb. 22-28 at the Kona Surf Hotel on the Big Island: Metabolism & Endocrinology, also by University of Washington Medical School.

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Include numbers of observations and the statistical significance of the findings when appropriate. Detailed statistical analyses, mathematical derivations, and the like may sometimes be suitably presented in the form of one or more appendixes.

Results: Present your results in logical sequence in the text, tables, and illustrations. Do not repeat in the text all the data in the tables and/or illustrations: emphasize or summarize only important observations.

Discussion: Emphasize the new and important aspects of the study and conclusions that follow from them. Do not repeat in detail data given in the Results section. Include in the Discussion the implications of the findings and their limitations and relate the observations to other relevant studies. Link the conclusions with the goals of the study but avoid unqualified statements and conclusions not completely supported by your data. Avoid claiming priority and alluding to work that has not been completed. State new hypotheses when warranted, but clearly label them as such. Recommendations, when appropriate, may be included.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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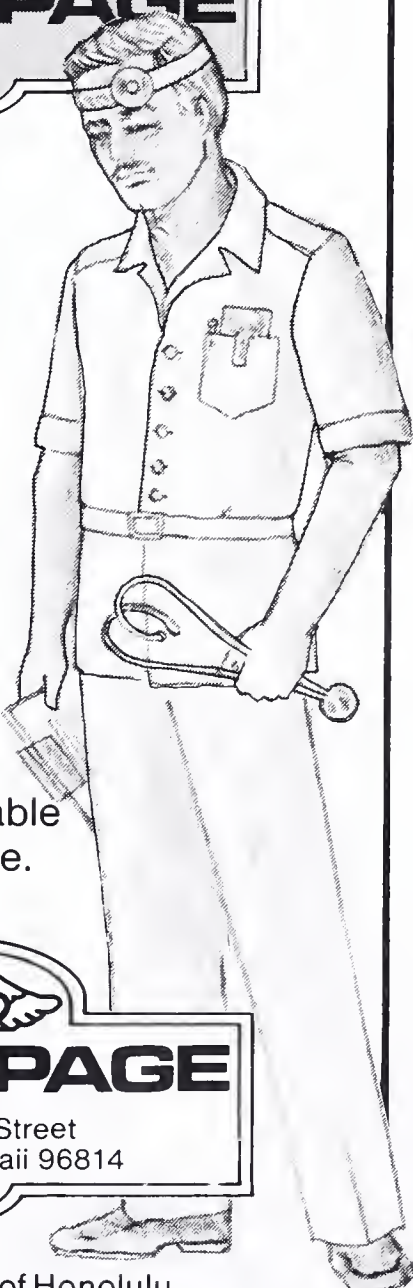
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Auditory Screening of High Risk Infants with Brainstem Evoked Responses and Impedance Audiometry

DAVID H. CROWELL, * Ph.D, GLENN PANG-CHING,† Ph.D, ROBERT E. ANDERSON,** M.D., LINDA E. KAPUNIAI,* M.P.H., KAZUO TERUYA, †† M.D., GENE DOO, †† M.D., PHYLLIS WRIGHT, *† M.D., and JANE K. STEPHENS, **†† M.A., *Honolulu*

Recent advances in audiologic assessment have shown a shift in measurement from behavioral to nonbehavioral responses. The purpose of this article is to describe the application of two nonbehavioral approaches, impedance audiometry and auditory evoked potentials, in measuring auditory responsivity in a group of infants at risk for hearing loss.

Assessment Techniques

Impedance Audiometry assesses middle and inner ear function and provides information relative to the type and extent of hearing loss. It has become a routine part of the audiological assessment of children and adults.¹ The efficacy of impedance audiometry with the very young has been demonstrated.^{2,3} The impedance test battery has three basic components: tympanometry, static compliance and acoustic reflex:

1) Tympanometry describes eardrum compliance changes as air pressure is varied in the external auditory canal. The basic datum is the

pressure-compliance function, a graph relating compliance change to pressure variation. Acoustic impedance at the tympanic membrane of a normal middle ear will increase if air pressure in the external auditory meatus is made higher or lower than ambient (atmospheric) pressure. This predictable relationship between changes in air pressure and changes in acoustic impedance is altered by abnormalities of the middle ear.

2) Static Compliance: This is a measurement of the change in stiffness of the tympanic membrane under two conditions: a) when it is first placed under a pressure of 200 mm H₂O and b) at its most compliant position. By recording these two points and by appropriate computation, the compliance of the ear in terms of an equivalent volume of air in cc or the absolute impedance in terms of acoustic ohms can be obtained. These measurements reflect the sound transmission characteristics of the middle ear system. Middle ear dysfunction can be expected to alter the compliance of the middle ear system.

3) Acoustic reflex: The middle ear muscles (stapedius and tensor tympani) contract when the ear is stimulated with a sufficiently loud sound. In measuring the crossed or contralateral acoustic reflex threshold, an acoustic stimulus is introduced to the ear opposite the ear in which a probe tip is sealed. When the acoustic stimulus is sufficiently loud to elicit the bilateral reflex, the resulting contraction of the muscles in the ear containing the probe tip will increase the impedance at the eardrum. In measuring the ipsilateral or uncrossed acoustic reflex threshold both probe tip and reflex eliciting signal are introduced in the same ear. The normal relation be-

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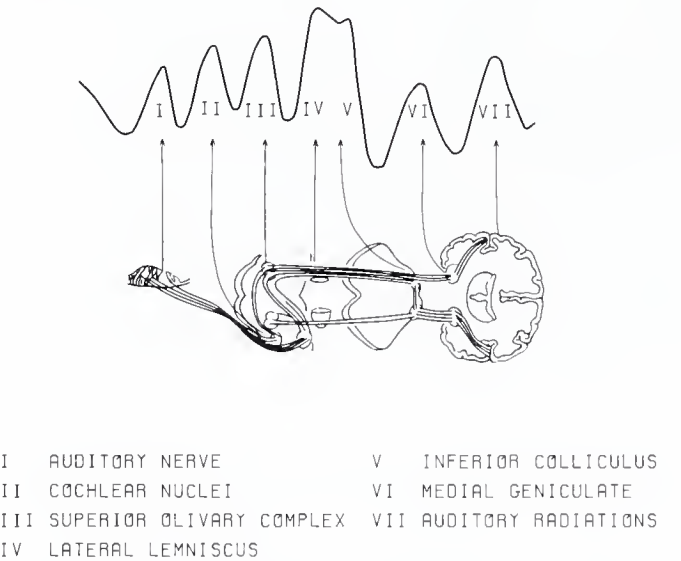
tween changes in acoustic impedance and contraction of the middle ear muscles is modified by middle ear disease, cochlear disease and lesions of the VII and VIII cranial nerves.

Auditory Evoked Potentials

The auditory evoked potential has been described in terms of early (within 5-10msec),^{4,5} middle (10-50msec)^{6,7} and late (50-500msec)⁸ EEG components which are detectable from surface electrodes on the scalp.

Current interest is centered mainly on the early component, or brainstem auditory evoked potential, referred to as BAER, BER, BEP, BSER and ABR. The BER is a response to an auditory stimulus detected from vertex and mastoid leads. The BER is a series of 7 waveforms which presumably reflect transmission through the various auditory nuclei and pathways,^{9,10} Fig. 1. Because these potentials are in the uV range, identification of the waveforms requires summation of many individual responses. This summation is the process of signal averaging and enhances the

FIG. 1.—Anatomical correlations of the brainstem auditory evoked response.



responses by increasing the signal-to-noise ratio. The presence of specific waves is an index of auditory integrity. These waves and latencies are related to maturation; in the case of the young organism, waves I, III, and V are present most often and the latencies longer than for the adult.^{4,11} Wave V has been shown to be the most reliable for diagnostic purposes in both infants and adults.

Clinical Application

These techniques were used on babies meeting high risk criteria which generally followed those recommended by A National Joint Committee on Newborn Screening.¹² These criteria are as follows:

- 1) Birth weight less than 1500 grams.
- 2) Birth weight of 1500-2000 grams with bilirubin level of 12 and above. Birth weight of

2000-2500 grams with bilirubin level of 12 and above. Birth weight greater than 2500 grams with bilirubin level of 18 and above.

3) All newborns with exchange transfusions for hyperbilirubinemia.

4) Maternal viral infections during pregnancy—including small-for-dates infants who are suspected of intrauterine viral infection.

5) Congenital abnormality of the external ear (exclusive of simple pre-auricular tags or pits), cleft lip/or palate and other recognized oral-facial abnormalities associated with deafness.

6) Family history of congenital hearing impairment. (Mother, father, siblings, maternal and paternal siblings.)

7) Infants who have had ototoxic drugs 7 days or longer.

Table 1 shows the total sample in terms of these high risk criteria.

TABLE 1.—Total sample of high-risk and normal subjects by risk criteria.

CRITERIA ^a	NO.
One minute Apgar score < 5	24
Hyperbilirubinemia	15
≥ 10 mg B.W. 1500-2000g (9)	
≥ 12 mg B.W. 2000-2500g (4)	
≥ 18 mg B.W. >2500 (2)	
Birth weight < 1500g	11
Ototoxic drugs > 7 days	10
Congenital anomaly of external ear, cleft palate	8
Maternal viral infection during pregnancy	7
PPC ^b graduate	6
Suspected hearing problem	5
Family history of congenital hearing impairment	3
MIC ^c patient	7
Normal newborn	4
Apnea	1
Mother's request	1
SIDS sibling	1

^aInfants are listed only once but may have had more than one criterion.

^bPediatric Pulmonary Center

^cMaternity and Infant Care Project

Impedance Audiometry

Impedance measurements were made with an American Electromedics model 83 electroacoustic bridge. Infants were placed in a supine or prone position; their heads were turned with one ear positioned over the earphone while the probe tip was positioned in the other ear.

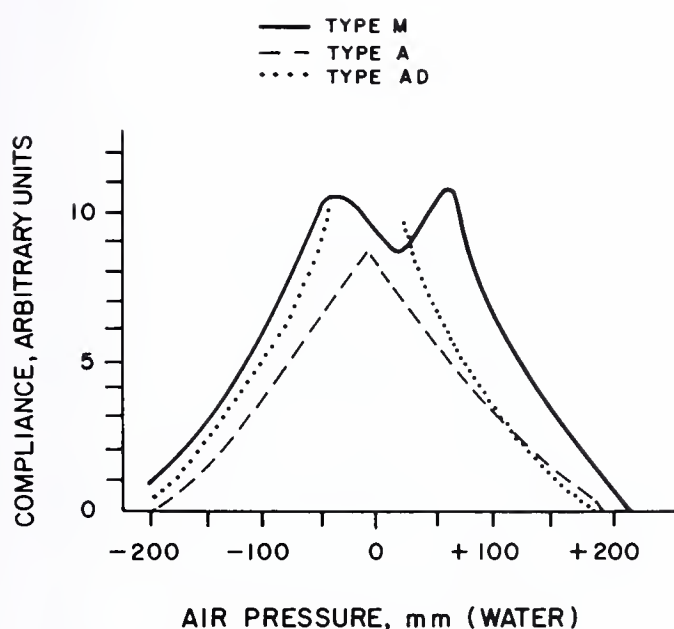
After obtaining a hermetic seal the 3 basic components of impedance audiometry were assessed. Tympanometry measurements were made by systematically manipulating pressure between +200 and -200 mm H₂O at 50mm intervals. The point of maximum eardrum compliance also was noted. Tympanograms were categorized according to Jerger's classification.¹ Following tympanometry, static compliance was assessed. Finally, acoustic reflexes were assessed to a variety of stimuli: for contralateral, 500,

1000, 2000 and 4000 Hz, white noise, high pass and low pass filtered noise up to a maximum of 100 Db and for ipsilateral 500, 1000, and 2000 Hz.

Impedance measurements were made on 63 babies who ranged in age from 1 to 101 days. Hermetic seals were obtained on 121 of the 126 ears (96%). Results are described in terms of the three components.

Tympanometry. In general the tympanograms, Fig. 2, assumed the well-defined notched configurations at atmospheric pressure reported for adults and older children.¹ In this sample, 96% showed the Type A (40%) or the deeply notched (Aa) tympanogram (56%), Fig. 2. The

FIG. 2.—Tympanogram configuration.



remaining 4½ had M shaped (double peaked tympanograms), Fig. 2. A more intensive investigation of Aa tympanograms (by noting the point of maximum eardrum compliance) demonstrated that there was a greater percent of M-shaped configurations, that is, 48 of 68 ears (70%). This double notched tympanogram has been taken to be an indication of a hypermobile eardrum^{2,3} and is relatively rare in older children and adults when a 220 Hz probe is employed. The combination of Aa and M tympanograms observed in this study lends further support to the belief that the tympanic membrane in the very young is hypermobile. These data are different from those reported.^{2,3}

Static compliance. The infant compliance measurement values, mean of 1.28 cu cm and a range of 0.3 to 2.70 cu cm, are suggestive of a very mobile middle ear system. These are consistent with reported infant compliance values,^{2,3} but higher than compliance values for older children and adults.¹ The compliance and tympanometric results complement each other and provide evidence for a relatively mobile middle ear system in the very young.

Acoustic Reflex

1. **Contralateral reflex.** The acoustic reflex data for all stimuli have been pooled since there did not appear to be any appreciable stimulus effect. The reflex could not be elicited in 90% of the ears. This may be attributed to a number of possible causes such as behavioral artifacts, maximum stimulus intensity employed (100dB), sleep state, and lack of complete neurological development of the contralateral acoustic reflex arc.¹⁴ These results should be interpreted in light of the percentage of infant contralateral acoustic reflexes reported in the literature which varies from a low of 5%¹⁴ to a high of 30-33%² Margolis and Popelka¹⁵ reported that with infants 55 to 132 days of age acoustic reflexes are invariably present.

2. **Ipsilateral reflex.** Only 37 of the 63 babies were assessed with both the contra- and ipsilateral reflexes. Although the contralateral reflex was present in only 10% of the ears, the ipsilateral reflex was evident 79% of the time. The absence of the reflex in the other 21% of the cases may be related to the same factors that affected the contralateral reflex.

Brainstem Evoked Response

BERs were obtained with a Nicolet CA-1000 clinical averager which includes the click stimulus production module, TDH-39 earphones and X-Y plotter. BERs were measured from vertex (Cz0if-020) and mastoid leads (A1,A2). Stimuli were 64 dB HL 100 μ sec clicks presented monaurally at 11.1/sec for 2000 artifact-free trials. Brain wave potentials were sampled for 10 or 20 μ sec after the click using band pass filters at 150 and 3000 Hz and sensitivity at 10 μ V. The average waveform for each ear was replicated and both waveforms plotted. Latencies to wave V were averaged over the two replications.

The BER was measured monaurally on 102 infants. These infants ranged in age from 34 weeks conceptional age (CA) at test to 50 weeks CA. There were 73 infants who had replicable wave V's in the right and/or left ear. The mean Wave V latencies and mean gestational ages are shown by CA groups in Table 2. The remaining 29 infants had nonreplicable or questionable recordings. In the case of premature infants seen prior to term waveforms may be undefined or difficult to reproduce and necessitate serial testing. The criteria which entered into the decision on adequacy of the BER waveform included: (a) presence of expected peaks, (b) reproducibility of peaks and (c) latencies which are within expected limits for age and stimulus intensity.

One-way analysis of variance showed there were significant age differences for Wave V latencies for both ears; for right ear $p=.001$ and for left ear, $p=.003$. There were no significant

TABLE 2.—Brainstem auditory evoked potential wave V latencies for infants with conceptional ages (CA) ≤ 37 weeks, 38-42 weeks and ≥43 weeks and gestational age.

	CA		
	≤37 weeks	38-42 weeks	≥43 weeks
Gestational age			
N	18	48	17
Mean	33.1	38.1	36.5
SD	2.2	4.1	4.1
Wave V Latency Left Ear			
N	16	39	15
Mean	7.96	7.61	7.26
SD	.41	.57	.36
Wave V Latency Right Ear			
N	15	39	15
Mean	8.01	7.58	7.27
SD	.38	.54	.31

differences between ears for any of the age groups, paired t test. The latencies in this study are consistent with the pattern of decreasing latency with increasing postnatal age.⁴ This conclusion must be interpreted in light of the sample which is primarily one of high-risk infants.

Case presentation

The following case studies illustrate the applications of these techniques.

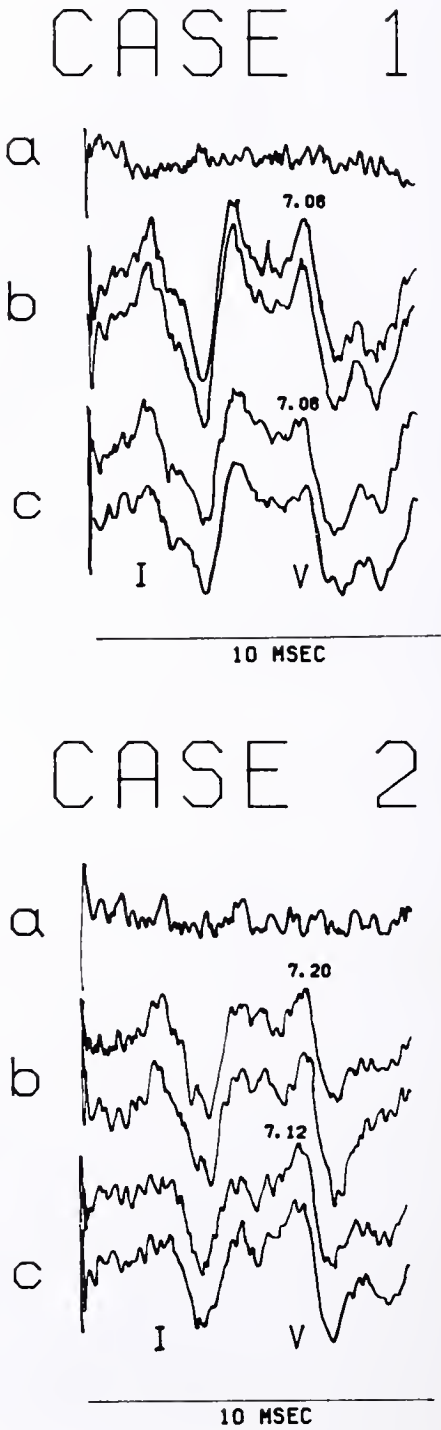
Case #1. This term female infant was born after an uncomplicated pregnancy and delivery with Apgars of 9 at 1 minute and 9 at 5 minutes. Birth weight was 3,062 grams. During the neonatal period the infant had mild hyperbilirubinemia, peak bilirubin of 14.9 mg%. At 1 month of age the infant was referred to the hearing screening study because of a family history of congenital hearing loss. Normal brainstem responses were clearly demonstrable, Fig. 3, Case 1, indicating normal brainstem auditory functions. This ruled out the presence of a congenital sensory neural hearing loss.

Case #2. This premature infant was born at 33 weeks gestation to a 16-year-old gravida 1, para 0 mother with Apgars of 5 at 1 minute and 6 at 5 minutes. The infant developed respiratory distress. She was intubated and transferred to the pediatric pulmonary care center with a diagnosis of early respiratory distress syndrome and prematurity. The hospital course was complicated by an intracranial bleed diagnosed by a bloody lumbar puncture on the first day of life. On the second day of life the infant experienced a pulmonary hemorrhage with a decreased platelet count and abnormal clotting studies. Other complications included a) patent ductus arteriosus which was ligated at one week of age, b) a prolonged course requiring ventilatory support, and c) hydrocephalus thought to be secondary to the CNS bleed and requiring a ventriculo-peritoneal shunt. The infant had seizure activity during the hospitalization and was placed on phenobarbital. In addition ototoxic

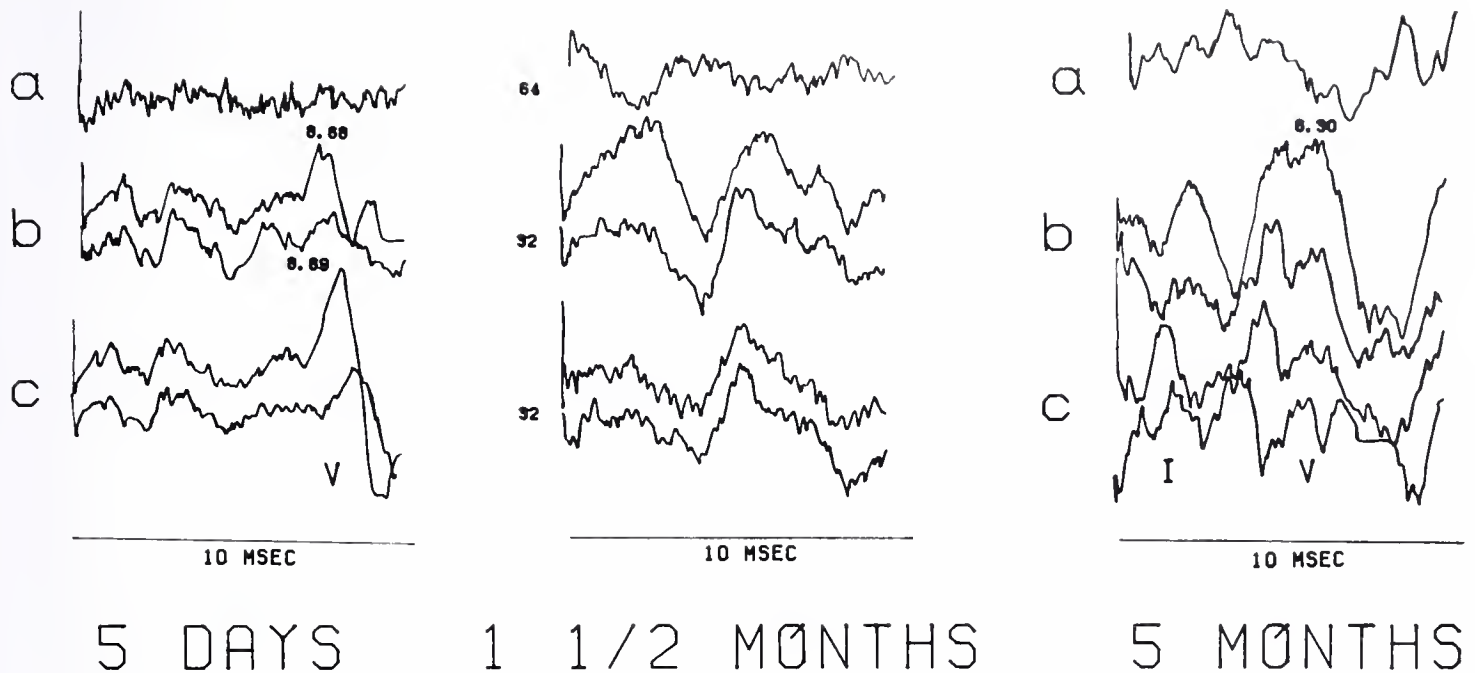
medications for suspected sepsis and for a documented urinary tract infection were required. She was transferred to a secondary care center at 10 weeks of age. After discharge, the infant was followed for problems of severe spastic diplegia and severe psychomotor retardation. She showed no response to voice or noise makers

FIG. 3.—Brainstem evoked potentials from three case presentations. Case 1, term female at one month conceptional age with family history of congenital hearing loss; Case 2, premature female with long hospital course requiring ventilatory support, hydrocephalus, spastic diplegia and psychomotor retardation tested at 2½ months of age; Case 3, premature male with hyperbilirubinemia and possible pre-conception exposure to rubella vaccine tested at 5 days of age, 1½ months and 5 months.

Each case includes waveforms from 2000 artifact free repetitions of 100 microsecond clicks at 64dBHL, at a rate of 11.1/sec. recorded from vertex and mastoid leads. Filter settings were 150-3000 Hz, sensitivity at 10µV. (a) 2000 samples of ongoing EEG, (b) two replications of the BER with right ear stimulated and (c) two replications with left ear stimulated. Average latencies in msec to replicated peak V are indicated in the figure.



CASE 3



and there was a question of her auditory responsiveness. Brainstem evoked response at 2½ months of age, Fig. 3, Case 2, clearly showed an intact brainstem auditory pathway. It was tentatively concluded that the lack of responsiveness may reflect cortical damage.

Case #3. This premature infant male was born to a grav. 1, ab. 1, para 0 mother at 35 weeks of gestation with Apgars of 8 at 1 minute and 9 at 5 minutes. The mother received rubella vaccine just prior to conception. Examination at birth revealed no physical deformities. The infant was treated in the intensive care unit for mild respiratory symptoms which were diagnosed as retained fetal lung fluid and resolved by 12 hours of age. Jaundice was noted at 24 hours of age. Direct and indirect Coomb's were negative. The infant was placed under phototherapy for a total of 48 hours with a peak bilirubin of 15.5 mg% on the third day of life.

In view of the premature labor, the history of this mother receiving rubella vaccine just prior to conception, and the hyperbilirubinemia, this infant was entered into the hearing screening project. The first recorded BER at 5 days of age did not show discrete wave patterns, Fig. 3, Case 3. It is not clear as to whether the inability to obtain good tracings was due to technical problems or a

transient abnormality as has been described in other premature infants. At 1½ months of age the tracings again were questionable, Fig. 3, Case 3. At age 5 months there was a more discernible wave pattern, Fig. 3, Case 3. Subsequent psychological testing at approximately 13 months conceptional age showed no definite evidence of any hearing problem.

Summary

State of the art advances in bioinstrumentation have led to 2 important techniques for assessing auditory responsiveness in the very young human. Impedance audiometry and the brainstem evoked response are two noninvasive techniques available to the clinician. Both are supported by anatomic and neurophysiologic evidence and thus provide meaningful evidence of auditory system integrity. These techniques are indicated for infants and children who fail to demonstrate consistent behavioral responses to auditory stimuli.

Acknowledgment

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REFERENCES

1. Jerger J: Clinical experience with impedance audiometry, *Arch of Otolaryngol* 92: 311-324, 1970.
2. Keith RW: Impedance audiometry with neonates, *Arch Otolaryngol* 97: 465-467, 1973.
3. Keith RW: Middle ear function in neonates, *Arch Otolaryngol* 101: 376-379, 1975.
4. Salamy A, McKean CM: Postnatal development of human brainstem potentials during the first year of life, *Electroenceph clin Neurophysiol* 40: 418-426, 1976.
5. Mokotoff B, Schulman-Galambos C, Galambos R: Brainstem auditory evoked responses in children, *Arch Otolaryngol* 103: 38-43, 1977.
6. Goldstein R, McRandle CC: Middle components of the averaged electroencephalic response to clicks in neonates. In SK Hirsh, DH Eldredge, IJ Hirsh, SR Silverman (Eds.): *Hearing and Deafness: Essays Honoring Hallowell Davis*. St. Louis Washington University Press, 1976, 445-456.
7. Wolf KE, Goldstein R: Middle component averaged electroence-

- phalic responses to tonal stimuli from normal neonates, *Arch Otolaryngol* 104: 508-513, 1978.
8. Crowell DH, Kapuniai LE, Jones RH, Pang-Ching G: Autoregressive analysis: a method for detecting electroencephalic changes in newborns to tones, *J Speech Hear Res* 23:248-257, 1980.
 9. Jewett, DL: Volume-conducted potentials in response to auditory stimuli as detected by averaging in the cat, *Electroenceph clin Neurophysiol* 28: 609-618, 1970.
 10. Buchwald JS, Huang C: Far field acoustic response: origins in the cat. *Science* 189: 382-384, 1975.
 11. Schulman-Galambo C, Galambo R: Brainstem auditory-evoked responses in premature infants, *J Speech Hear Res* 18: 456-465, 1975.
 12. Northern JL, Downs MP: *Hearing in Children*. Maryland: Williams and Wilkins, 1974, pp. 108-109.
 13. Alberti PWR, Jerger J: Probe-tone frequency and the diagnostic value of tympanometry, *Arch of Otolaryngol* 99: 206-210, 1974.
 14. Keith RW: Acoustic middle-ear muscle reflex in neonates. Paper presented at American Speech and Hearing Association Convention, Chicago, 1977.
 15. Margolis RH, Popelka GR: Static and dynamic acoustic impedance measurements in infant ears, *J Speech Hear Res* 18: 435-443, 1975.

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The Use of Infants' and Childrens' Occupant Safety Devices in Motor Vehicles: An Observational Study

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Motor vehicle accidents are a major cause of infant and child mortality and morbidity in the United States. After the first year of life, motor vehicles pose the single greatest threat to the lives of children.¹ Annually about 2,700 deaths to passengers in motor vehicles occur in the 1-15 year age range, more than the 6 other leading causes of childhood mortality combined.² In spite of these statistics, which clearly indicate the risk to future generations, the need for protection in motor vehicles for infants and young children continues to receive less than adequate attention from government, industry, or the medical profession.

During one's lifetime, if the national trends continue, the average U.S. citizen will have a 50% chance of receiving a disabling injury and a 2-3% chance of dying in a motor vehicle accident.³ Studies do not agree on the percentage of effectiveness of automotive safety restraint systems. Nevertheless, they all agree that risk of death or disability from automobile accidents can be greatly reduced by the use of safety restraint systems. A 5-year review on seat belt usage by the Washington State Highway Patrol in 1974 disclosed that 19,061 occupants in motor vehicle accidents were under 5 years of age. No fatalities were reported among those 2,880 (15.1%) who were in a protective safety restraint. However, of the 16,181 children not restrained, 82 (0.5%) were killed outright or died as a result of injury.⁴

In Hawaii, the same pattern of death and injury to children occurs on our highways. In

1977, accidents were the leading cause of death in infants and children from ages 1-19.⁵ Over a 5-year period, 1973-77, a total of 713 fatalities were reported in Hawaii due to motor vehicle accidents. This represents an annual average of 143 deaths for all ages; 35 (24.8%) were in the 0-19 age group, and 3 (2.3%) were in the 0-4 age group. During the same 5-year period, an annual average of 11,270 injuries was reported. In the 0-19 years age group, there were 3,280 (29%) and 411 (3.7%) in the 0-4 years age group.⁶ (This is grossly underreported. On Oahu only, an estimated 3,500 children are treated annually in hospital emergency rooms for injuries sustained in automobile accidents.) Based on studies from other states, these figures represent deaths and injuries to children in automobiles that could have been prevented or substantially reduced by the proper use of efficiency tested auto passenger safety restraint systems.

A statewide program to increase the use of automobile passenger safety devices for infants and children has been developed by the Maternal and Child Health Unit of the University of Hawaii, School of Public Health, via funding from the Hawaii State Department of Transportation. This observational study was conducted prior to its inception in order to establish a baseline for evaluating the program.

Observation

Observations were made on 2 consecutive Saturdays, between 9:00 a.m. and 3:00 p.m., during the month of November, 1979, at Ala Moana and Pearlridge Shopping Centers, the two largest shopping centers on the Island of Oahu. These shopping centers are frequented

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by a fairly good cross section of the socio-economic and ethnic groups from urban Oahu. The driver of each vehicle selected was asked the age(s) of child passenger(s). To allow for a random and unbiased selection of the sample, only those vehicles whose last digit in their license plate number was odd were chosen for the study. In order to obtain a sample size adequate to perform statistical analysis with reliability, a minimum of 120 observations was required.⁷

For the vehicle to be included in the study, the following criteria were met:

- 1. A private passenger motor vehicle, excluding buses, vans, and trucks;
- 2. The vehicles selected contained a minimum of one child less than 11 years old, riding in any position.

To be considered restrained, the following criteria were met:

- 1. If the child was less than 4 years old, (s)he had to be using a car restraint system approved by Federal Safety Standards.⁸
- 2. If the child was 4 years of age or older, (s)he had to be sitting in a forward position with the seat belt buckled.
- 3. The child had to be properly restrained by the system used.

Results

A total of 146 adult drivers and 229 occupant passengers under the age of 11 years was observed. There was nearly equal distribution between the male and female drivers, 51% and 49% respectively. The distribution of children between the two age groups was also nearly equal: 48% (110) were 4 years or less and 52% (119) were 5 to 11 years of age. (See Table 1) The safety restraint usage patterns of the children were 7% (15) restrained; 93% (214) were not restrained.

TABLE 1.—Observed Automobile Occupant Safety Restraint Usage by Children, ages 0-11, in Urban Oahu, November, 1979

AGE OF CHILD	RESTRAINED	NOT RESTRAINED	TOTAL
<4 YEARS	11 (10%)	99 (90%)	110 (100%)
4-11 YEARS	4 (3%)	115 (97%)	119 (100%)
TOTAL	15 (7%)	214 (93%)	229 (100%)

Of the 110 children 4 years of age or less, 10% (11) were restrained and 90% (99) were unrestrained. Of the 119 children 5 through 10 years, 3% (4) were restrained and 97% (115) were not restrained. Of the 15 children restrained, 73% (11) were 4 years of age or less and 27% (4) were 5 to 11 years old.

Overall, driver use of seat belts was low, 7%. (See Table 2) Of those drivers using restraints, 80% (8) were men and 20% (2) were women. While the apparent difference is large, the use among men is only 11% compared to 3% in

TABLE 2.—Observed Safety Restraint Usage in Automobiles in Drivers in Urban Oahu, November, 1979

DRIVER	MALE	FEMALE	TOTAL
RESTRAINED	8 (11%)	2 (3%)	10 (7%)
NOT RESTRAINED	66 (88%)	65 (91%)	131 (90%)
UNKNOWN	1 (*)	4 (6%)	5 (3%)
TOTAL	75 (99%)**	71 (100%)	146 (100%)

*Number too small for reliable percentage.

**Not 100% due to rounding.

Note: Chi-Square=5.46, 2 df (P>.05)

women and the difference is not statistically significant. (P=.05.) Of those drivers not restrained, 50% were male and 50% were female. Five drivers not reliably observed as to whether they were wearing an auto safety restraint included 4 women and 1 man.

The relationship between the drivers' use of seat belts and infants' and childrens' use of seat belts and other occupant safety devices was examined. (See Table 3) The cars in which the drivers wore seat belts contained 9% (20) of the children, and 15% (3) of them were protected by safety restraints. In the cars where the drivers did not buckle up were 88% (201) of the children, with only 5% (11) of them properly restrained.

TABLE 3.—Automobile Safety Restraint Usage by Driver by Occupant-Child in Urban Oahu, November, 1979

DRIVER (N=146)	CHILD-OCCUPANTS		TOTAL CHILD-OCCUPANTS
	RESTRAINED	NOT RESTRAINED	
RESTRAINED (N=10)	3 (15%)	17 (85%)	20 (100%)
NOT RESTRAINED (N=131)	11 (5%)	190 (95%)	201 (100%)
UNKNOWN (N=5)	1 (12%)*	7 (88%)	8 (100%)
TOTAL	15 (7%)	214 (93%)	229 (100%)

*Number is too small for reliable percentage.

While the difference in percentage points is large (10%) due to the small number in one sub-sample (20) and large number (201) in the other sub-sample, the difference was found not to be of statistical significance when the most appropriate statistical test was applied. (Using Fisher Exact Test the difference was significant at the .14 level but not at the .10 level.) By analysis of variance the difference was barely significant at .10 level and the T Test was significant at the .049 level.

Discussion

This study of use of automobile occupant safety restraint systems indicates an alarmingly low use for children (7%) under 11 years of age, as well as a very low use for adult drivers (7%). While the level of use is considerably lower than that reported by states based on data from accidents,^{1,2} it is almost identical to the level reported in an observational study from 3 states. In that tri-state large observational study (5,050 obser-

vations not involving accidents),⁴ 93% of the passengers 10 years of age or younger were not restrained, identical to the observation in this study. In the tri-state study, however, even though child passengers were more likely to be restrained if the driver was restrained, 75% of the children were unrestrained even when the driver was restrained. In this study, while there was a 10% increase in use of protective restraint devices by infants and children when the driver was wearing a seat belt, this is of borderline statistical significance. However, the fact remains that 85% of the infants and children were not protected by occupant safety restraint devices even when the driver was using a seat belt. The adults' concern for their own protection did not in most cases extend to using safety restraint devices for their children.

Of interest, anecdotally, were the defensive responses of many of the drivers (assumed parents), even though the only questions asked were to determine the age of the children. These included:

"My kids are usually buckled up,"

"My child just won't ride in it,"

"I know we should, but it's so much trouble."

Many questions need exploration as to why and when people choose to use or not use auto occupant restraint devices for their children and themselves. These responses represent only a few areas in which more information is needed to plan effective intervention strategies which would facilitate change in the behavior of adults and children and thus prevent deaths and injuries.

It is generally accepted that the physician has a potentially strong influence over the attitudes and behaviors of patients. The opportunities are extensive in this area of prevention, regardless of specialty. Parents as role models strongly influence the behavior of children. If physicians are able to influence only a few adults to routinely use seat belts, the domino effect should influence the protection and behavior of many infants, children and future adults. The attitudes of the

driver-parents indicate a variety of areas which health professionals need to address. The non-use of seat belts is apparently not considered a potential health problem by either children or adults.

This study strongly indicates a need for an intervention program which will aid in reducing this significant hiatus between accidental facts and practice, and thereby reduce the mortality and morbidity of infant and child passengers in automobiles. Health professionals are an essential component of such a program and can assist by increasing the awareness and understanding of both children and adults that a health problem exists. Not only by advocating the use by all patients of dynamically tested auto safety restraint systems but by becoming role models as well, health professionals may help children and adults to change this life style related behavior.

Summary

A study of the use of automotive protective restraint systems carried out in urban Oahu demonstrates alarmingly low levels of use by infants and young children, as well as by drivers. Overall, infants and children through the age of 10 years were unprotected 93% of the time. Drivers were unprotected at least 90% of the time. Physicians and other health professionals are called upon to aid in intervention programs to increase the usage of occupant protective devices in order to eliminate this major cause of deaths and injuries to infants and young children.

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REFERENCES

1. Shelness A, Charles S: Children as passengers in automobiles: the neglected minority on the nation's highways, *Pediatrics*, 56:271, 1975.
2. Lieberman, HM, Emmet, WL, Coulson, AH: Pediatric automotive restraints, pediatricians, and the academy, *Pediatrics*, 58:316, 1976.
3. Accident Facts, National Safety Council, Chicago, 1975 Edition.
4. Seat Belt Study, Washington State Highway Patrol, 1974.
5. Statistical Report, Department of Health, State of Hawaii, 1977.
6. Unpublished data from the Motor Vehicle Safety Office, Hawaii State Department of Transportation.
7. Cochran WG, Cox GM: *Experimental Designs*, John Wiley and Sons, Inc., Second Edition, New York, c. 1960.
8. Code of Federal Regulations, (49) Chapter V, National Highway Traffic Safety Administration, Department of Transportation Standard No. 213, Child Seating Systems, pp. 954-958.



Union Label

Following the recent publicity concerning possible formation of a physician's union, the Hawaii Medical Association sought opinions from the AMA. The following statements were subsequently released, and were posed to Sanford A. Marcus, M.D., President of the Union of American Physicians and Dentists.

1. Groups of private contractors, such as privately practicing physicians, will be able to act or not act, to exactly the same extent of a medical society.

Reply: "Only half-true. Collective bargaining with employers is one important area wherein our Union has been particularly successful; this function cannot legally be served by a medical association. Otherwise, it is true that all other functions of our Union could be handled by the HMA. I stress 'could' because historically, this has never happened; the AMA made it clear: 'AMA is not, and cannot be, a union.' We would welcome any medical organization capable of effectively and vigorously assuming our functions."

2. Groups of independent contractors, whether they call themselves a "union" or not, are *not* exempt from antitrust actions, such as strikes, boycotts, price-fixing, as are true unions.

Reply: "This strike issue is a straw man. Our Union has never called a strike and never will. Nevertheless, we have evolved many very effective 'job actions' which have suited our purpose admirably. We carefully avoid activities which might be considered contrary to antitrust legislation."

"Our chief efforts have been 1) in handling insurance grievances for members and their patients; 2) in negotiating with employers; 3) in dealing with hospital regulations which are contrary to patients' and physicians' interests; and 4) in grappling with government at all levels, including payment schemes (DSS, Medicare) and subsidiaries (PSRO, SHPDA)."

3. In order for a group to fall under exemptions from antitrust laws, it must be a labor union with a labor purpose; by legal definition a "union" is comprised primarily of employees, and has the principal purpose of dealing with employers for wages, benefits, and working conditions.

Reply: "Correct. Only about 25% of our members would be considered employees by that particular definition. The IRS, however, defines an employee by the 'degree and regularity of control exerted upon him by others,' particularly those paying him. Since most of you are pretty effectively and regularly controlled by HMSA, DSS, Medicare, PSRO, JCAH, and SHPDA, for example, you're actually employees of a loosely-regulated public utility. Physicians only *appear* to be independent contractors; the persistence of this illusion has permitted our increasing regulation without protest."

4. Physicians, as independent contractors, do not, and will not fall under these (antitrust exempt) provisions, even if a group calls itself a "union." Such cases where employer/employee relationships exist occur only in the State Health Department or in housestaffs.

Reply: "Half true: don't forget many hospital-based physicians, and those working for Kaiser, Straub, and the Medical Group. Then there are schools, IPAs, CHPs, and the University. But the point remains that we are not concerned with employment status as it reflects Union liability to antitrust laws: we studiously avoid actions proscribed by these regulations. That would include publishing a new RVS, unfortunately."

"In summary, except for collective bargaining, the HMA can do everything that our Union does. But in California (as elsewhere) the fact that the CMA has not, can not, and apparently will not get into the socioeconomic arena and grapple for physicians and their patients, has produced the continued growth of our Union. We must be filling a void, for our members seem to feel they are getting their money's worth. I believe that medical associations, representing as they do a broad constituency of relatively conservative physicians, do not find it politically feasible to battle in the controversial arenas in which we find ourselves. Most medical societies feel they function best in scientific, educational, and peer-review activities; we are concerned with socio-economic matters. Can our roles not be complementary?"

JMC

Dialogue

HMA: Why did PSRO spend \$300-million on medical Utilization Review last year?

FED: Because we're trying to cut medical costs.

HMA: But the Congressional Budget Office found PSRO's overall saving was 40¢ for

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each dollar spent . . . and some programs saved as little as four cents every buck!

FED: Well, the government spends \$57-billion a year on Medicare and Medicaid alone (that's \$156-million every single day!), so we must at least try to get our money's worth.

HMA: *Your* money's worth?

FED: The people's money. We need to look out for it, and spend it wisely for them.

HMA: You think "wise spending" means paying a dollar to save 40¢? Why not simply give the people their money back and let *them* look out for it, and spend it wisely for themselves? Government schemes can't even touch the low overhead of private insurance.

FED: Well, some of the people don't have it to spend. Our transfer-of-payments programs take from the "haves" and pay bills for the "have nots."

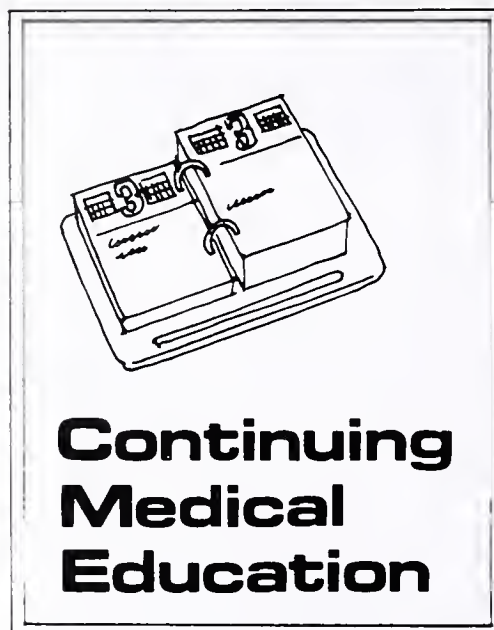
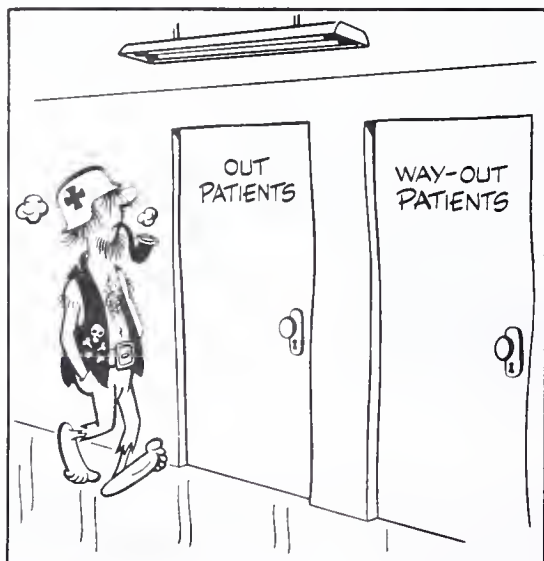
HMA: There'd be fewer "have nots" if they could keep their rightful earnings. Why not let the people "transfer" their money individually, through local programs of taxation and donation, to persons known by their neighbors to be needy? Even the state legislature is more efficient than HEW!

FED: That's so provincial. We need national programs for national needs.

HMA: Many "national needs" are the result of attempts to solve local problems in Washington: the bigger these programs, the greater the waste. Government is seldom a solution; increasingly, it seems to be the problem. Why can't you let people handle their medical bills in the same way they do their grocery bills?

FED: This is different. We in Washington know what's best for the country. Speaking of groceries, we are developing a plan for a new multi-billion dollar Food Stamp agency . . .

JMC



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

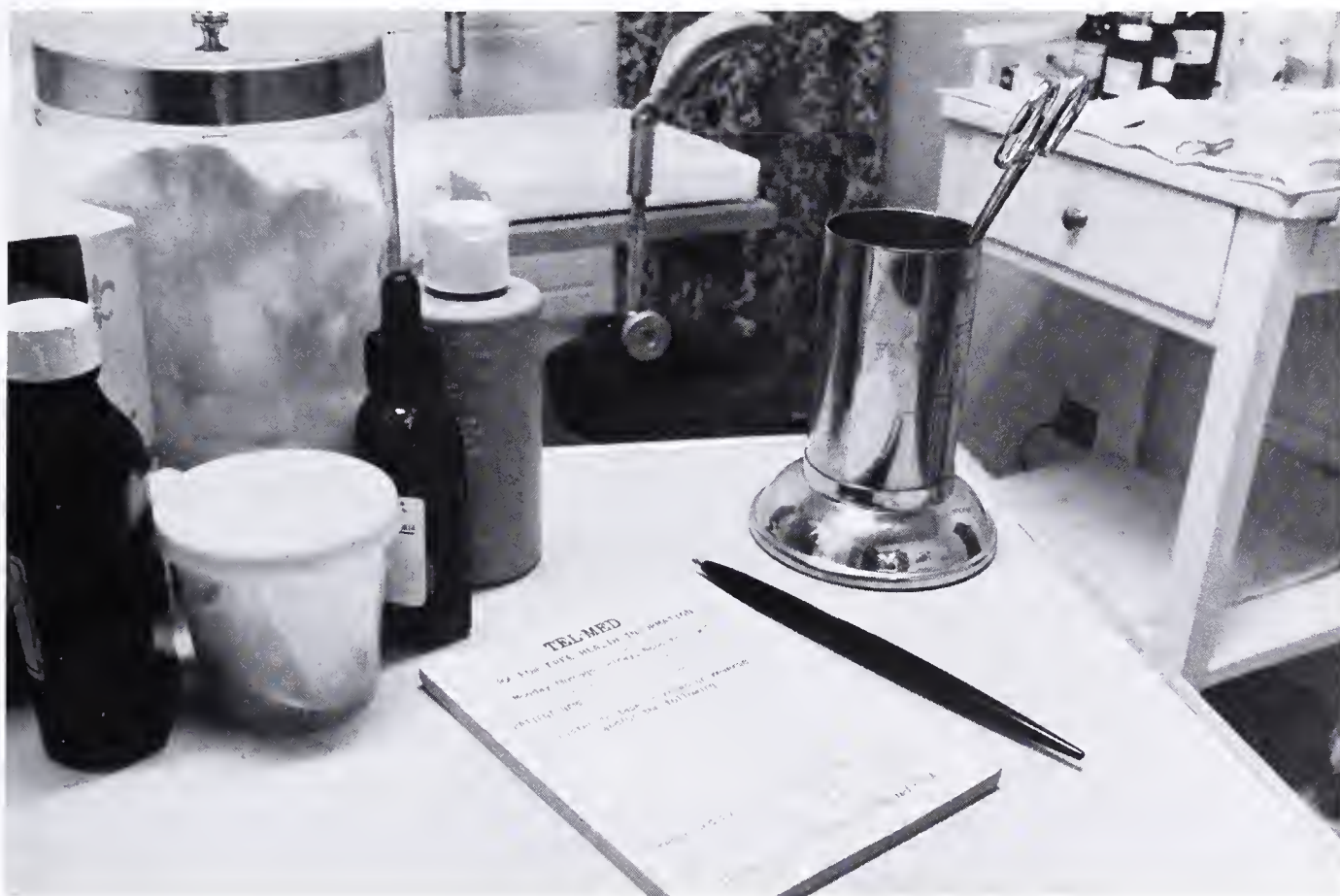
1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

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- B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1.
 - A. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 - B. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respiro, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.

2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
 2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
 3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea mnth. 8:00 a.m. 1 hr. Cat. 1.
 4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
 5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.
- (Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 - First—Didactic Presentation
 - Second—Perinatal-Neonatal Topics
 - Third—Obstetrics Topics
 - Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Internal Medicine Dept. Mtg., Second Tuesday, Evening, 5:30 p.m.
2. Department of Ophthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
3. G. I. Conference, Third Tuesday, 8:00-9:00 a.m.
4. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
6. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, Third Thursday, 1:00-2:00 p.m.
8. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
9. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 - 1st—Dept. of Medicine
 - 2nd—Dept. of Surgery
 - 3rd—Dept. of OB/GYN
 - 4th—Dept. of Pediatrics
 - 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.

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2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

Dec. 1-5, 1980 Modern Concepts in Clinical Cancer Management. Community Cancer Prog. of HI/Hawaii Medical Assoc. Held on Oahu & Neighbor Island Hospitals. For further info contact: Ms. Brannon-(808) 548-8777.

Dec. 1, 5, 1980 AMEDD Child Psychiatry Symp. TAMC/US Dept. of Army Off. Surg. Gen. Held TAMC, Honolulu 96859. 5 days, 35 hrs.

Dec. 3, 1980 Advanced Workshop for Laryngectomy Rehabilitation. American Cancer Society-Hi Div. Held: Conf. Rm B-2 Tripler AMC, Hawaii. 8:00a.m.-4:45p.m. Fee \$10.00 7 hrs. Cat. I. Advance Registration required-deadline Dec. 1. Contact: Donna Farr, ACS, (808) 531-1662.

Dec. 4-6, 1980 "Gynecological Surgery," sponsored by the American College of OB/GYN. 16 hrs. Cat. I. To be held at Hyatt Regency, Waikiki.

Dec. 11-14, 1980 Am. Med. Joggers Assoc. Contact: Hugh S. Ames; Honolulu Marathon Assoc. P. O. Box 27244, Chinatown Station, Honolulu, HI 96827.

Dec. 14-20, 1980 Immunohematology: New Concepts in Clinical Applications. Spons.-U of Penn. Schl of Med., & International Cntr. for Hlth Ed. Contact: Robt. Schmidt, M.D. International Cntr. for Hlth Ed., P. O. Box 3109, Lihue, Kauai, HI 96766 (808) 245-2121. Held at Kauai.

Jan. 10, 17, 1981 Perinatal Med. U of So. CA Schl of Med, 2025 Zonal Ave. LA, CA. Held at Royal Lahaina Htl, Maui. 4 days, 24 hrs.

Jan. 12-14, 1981 Practical Perinatology-Pediatric Postgrad. Course. U of HI. Held at Honolulu. 12 hrs. Cat. I. For further info contact: Wilma Schiner, 1319 Punahou St., Honolulu 96826, (808) 947-8511.

Jan. 15, 22, 1981 Med. Staff of Iowa Lutheran Hosp-Postgrad Conf. Iowa Lutheran Hosp, De Halder, Exec Sectry, U at Penn Ave., Des Moines, IA 50316. Held: Kauai Surf Htl, Kauai. 6 days, 24 hrs.

Jan. 18, 25, 1981 Sixth Ann Hawaii Hosp Med Staff Conf., Estes Park Inst. w/Queen's Med Cntr. Kauai Surf Htl, Kauai. Estes Park Inst., Box 400, Englewood, CO 80151. 5 days, 32 hrs.

Jan. 24, 31, 1981 Internatl Diagnostic Radiology. U of CA, Extended Prgms in Med. Ed., Dept. of Radiology, Rm M 396, 3rd & Parnassus Ave., San Fran, CA 94143. Held on island of Hawaii. 5 days, 40 hrs.

Jan. 26, 29, 1981 Adv. Sems. for Phys. Administrators & Trustees. Estes Park Inst., Box 400, Englewood, CO 80151. Held: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 15 hrs.

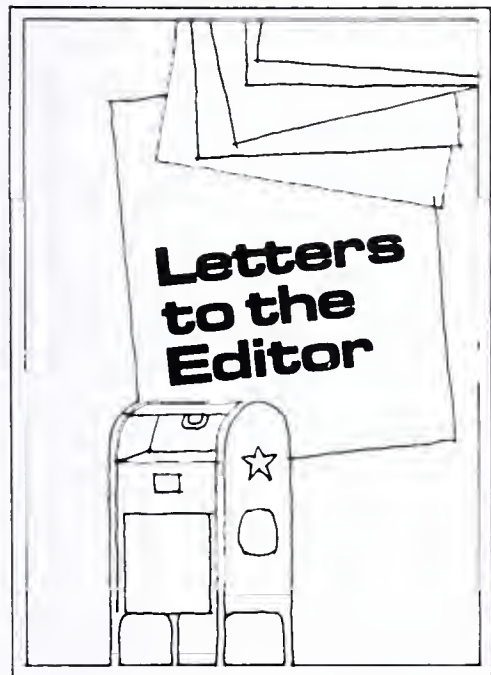
Feb. 1, 8, 1981 Clinical Allergy. J. A. Burns Schl of Med., U of H. Honolulu, HI. Held: Hyatt Regency, Maui. Contact: Dee Chang, (808) 947-8573 or 948-7457.

Feb. 3, 5, 1981 Office Dermatology for the Primary Care Physician. J. A. Burns Schl of Med., 1960 E-West Road, Honolulu, 96822. Co-sponsor: Hi Chapt. AAFP. Held at Kahala Hilton Htl, Honolulu. 3 days, 12 hrs.

- Feb. 5, 6, 1981 Third Symposium on Diabetes in Asia and Oceania. J. A. Burns Schl of Med. Honolulu. Held: Kobe Univ. School of Medicine, Honolulu.
- Feb. 16, 20, 1981 Symp on Preleukemic & Acute Nonlymphocytic Leukemia. J. A. Burns Schl of Med. Held: Hyatt Regency, Honolulu. 5 days, 25 hrs.
- Feb. 21, 28, 1981 Metabolism & Endocrinology. U of Wash CME SC-50, Seattle 98195. Co-sponsor-Wash State Med. Assn. Held: Kona Surf, Kona, HI. 7 days, 49 hrs.
- Feb. 23, 25, 1981 Postgraduate Course in Vascular Surgery. Am Col of Surgeons/co-sponsor J. A. Burns Schl of Med., U of H. Held at Hawaiian Regent Hotel, Honolulu.
- Mar. 2-6, 1981 Surgical Diagnosis & Therapy Phil Thorek Pstgrd. Courses, 850 Irving Park, Chicago, IL 60613. Hcls-Kauai 20 hrs. Cat. 1
- Mar. 16-20, 1981 Sports Medicine Course-U of HI J. A. Burns Schl of Med. Box CE-CCECS, 2530 Dole St. Honolulu 96822. Cospons: AmAcadFam-Phys. Held: Waikiki. 18 hrs. Cat. 1.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



Harry L. Arnold, Jr., M.D.
Hawaii Medical Association
320 Ward Avenue
Honolulu, Hawaii 96815

Dear Dr. Arnold:

The Editorials in the HAWAII MEDICAL JOURNAL are excellent. John Corboy's style is clear, cutting, easy and fun. I look forward to the Journal each month to enjoy John's clear stories about "sun lamps and slippers." Thank you for maintaining him as an Associate Editor.

Sincerely,

ROBERT C. ALLIN, M.D.



Friday, September 5, 1980

HMA CONFERENCE ROOM

PRESENT:

Drs. Bell, Winn, Lum, Hindle, Goto, Chinn, Iaconetti, Kam, Lambeth, Chun-Hoon, Lumeng, Morgan, Shirasu, Cahill, Fong, McNamee, Wigle, Fu, Mills, Saiki, Lee, Mr. V. Thomas Rice, Mmes. May Kim, Nancy Simmons, and Carol McNamee. HMA Staff present were: Messrs. Won, Ajifu, Jones, Leinweber; Mmes. Kendro, Chang, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Bell at 5:50 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of August 31, 1980 which indicated that HMA membership totaled 911 as compared with a total of 896 in August 1979.

REPORT OF THE TREASURER:

The July 1980 financial statement was reviewed in detail and approved subject to audit.

The purpose of this meeting was primarily to review the proposed 1981 HMA Budget as recommended by the Finance Committee. A detailed, line-by-line review of the budget items was conducted, with Council taking into consideration explanatory notes of the committee and various budget requests of committees and programs. A lengthy discussion ensued as a result of Council's efforts to develop a balanced budget.

ACTION:

It was moved, seconded, and passed to accept the recommendations of the Finance Committee; and to approve the proposed 1981 HMA Budget, as amended, for submission to the House of Delegates.

ACTION:

It was moved, seconded, and passed that the continued viability of the HAWAII MEDICAL JOURNAL be studied.

In discussing HMA's roster, Council reiterated that the roster be made available to non-members for \$20 per copy.

Council also reviewed the proposed Building Fund Budget for 1981 as proposed by the Building Committee.

ACTION:

It was moved, seconded, and passed to approve the proposed 1981 Building Fund Budget, as amended, for submission to the House of Delegates.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Medical Malpractice Insurance Crisis Committee:

Dr. Thomas Cahill reported for the committee and circulated a copy of Attorney Edmunds' findings from his recent trip to Pennsylvania. The Committee's recommendations to proceed to obtain a rate review hearing before the Hawaii Insurance Commission will require a substantial amount of funds. Dr. Cahill discussed various alternatives for raising the necessary funds including a mandatory assessment of HMA members.

ACTION:

It was moved, seconded, and passed that the question of a mandatory assessment of \$75 be referred to the HMA House of Delegates for favorable consideration.

B. EMS: Dr. Stanley Saiki reported that the correct draft of the 1980-81 HMA-SDOH contract for services to be performed by the EMS Program was submitted to the DOH's EMS Branch today. It is anticipated that the contract will be finalized within the next week and that funds would be forthcoming shortly. Council noted that HMA has been advancing funds to meet the responsibilities of the EMS contract, which has resulted in a loss of interest income for HMA during the year. It was the general feeling of the Council that every effort should be made to have funds advanced to the HMA at least quarterly, to enable HMA to meet the financial obligations of the EMS contract without utilizing the Association's resources.

ACTION:

It was moved, seconded, and passed that the HMA Executive Committee and representatives of the EMS Board request a meeting with the Executive Office of the State of Hawaii, to ask that a memorandum be issued to State department heads to ensure that EMS contract negotiations and financial obligations be handled in an expeditious manner.

OTHER BUSINESS:

A. Report of Pacific PSRO President: Dr. Winfred Lee brought the Council up to date on the preliminary findings of the Department of Health Human Services' recent audit of PacPSRO and the associated problems. The PacPSRO is scheduled to separate administratively from the HMA on October 1, 1980. There are various questions regarding rental agreements, employee pension plan funds, etc. Mr. Won briefed Council on negotiations with PacPSRO that have occurred thus far on issues related to the separation. Dr. Lee pointed out the concerns of PacPSRO regarding several issues and requested that further consideration be given to these matters prior to the official separation.

ACTION:

It was moved, seconded, and passed that the President appoint an ad hoc committee to review the issue of the pension plan, with report back before the House of Delegates meeting in mid-October. There was one opposing vote.

ACTION:

With regard to the issue of lease rent, it was moved and seconded that PacPSRO be requested to sign a

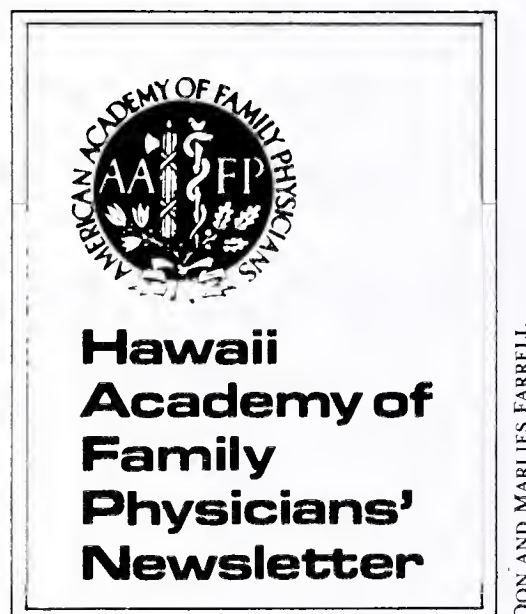
document with the HMA for rental of office space at \$2.00 per square foot per month with such rent to be discounted to \$1.15 per square foot per month until the expiration of PacPSRO's current contract.

ACTION:

In a substitute motion, it was moved, seconded, and passed: (1) that the issue of lease rent per square foot for office space made available to PacPSRO be combined as an item of study by the ad hoc committee which will review the retirement fund, with report back for House of Delegates meeting in mid-October; and (2) that the rent for PacPSRO shall remain at \$1.15 per square foot until such time that this committee reports back its findings. There was one opposing vote.

ADJOURNMENT:

The meeting was adjourned at 11:10 p.m.



News of members: Congratulations to **Robert Millard** who received the Robins award as Physician of the Year at the HMA's annual meeting. He is a charter member of our Chapter and has been in practice for well over 50 years . . . Becoming ever more active, **Tom Cahill** not only serves as Councillor and Commissioner for Medical Services with HMA, he is also running for President Elect of the County Medical Society . . . **David Swanson**, former president of our Chapter, has left the Army and is heading a FP training program in North Carolina.

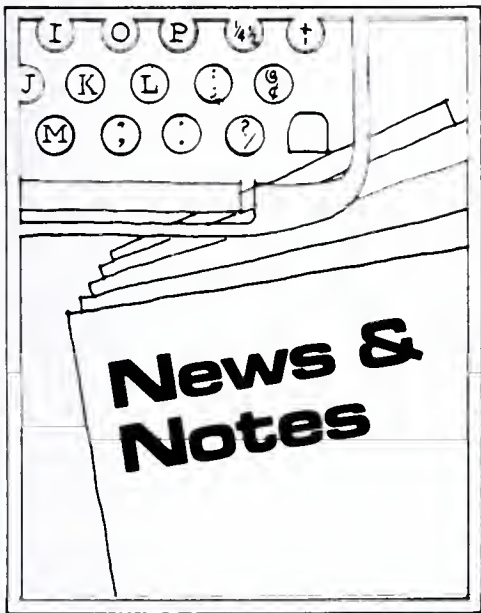
Don Farrell and **Tom Cahill** report on the actions of the Congress of Delegates in New Orleans. Some of the highlights include: "PI" credit reverts to the familiar "E" after one short year . . . FP input is again required for a course to receive "P" credit . . . AAFP opposes separate specialty of Geriatrics . . . Practicing Affiliate becomes Affiliate and members in this category cannot serve as council members or officers . . . Inactive members **must** be completely retired from practice or disabled . . . Life members in addition to having reached age 70, must now have been Academy members for 20 years rather than 10.

The date for **our annual meeting** has been changed in order to accommodate National President **Sam Nixon's** schedule. He will be here to install newly elected officers. We also hope to welcome **Dona Flory** from the Computerized CME Records Department in Kansas City. This will give members a chance to vent their gripes concerning their computer printout to the proper person . . . The seminar scheduled in conjunc-

tion with the annual meeting promises an excellent range of topics and speakers, so plan now to attend on **Feb. 14, 1980 at the Ilikai**. Programs and reservation forms will be sent out shortly, watch your mail.

The November **Dinner Meeting** was an outstanding success. Hosted by **Bob and Dolores Todd** in their spacious and historic Fort Kam home, it featured a program on "Depression Today" with **George Manning**, a Kaiser psychiatrist as moderator. 58 members and guests enjoyed not only the presentation, sponsored by Merrel-National Laboratories, but also an evening of fine food, including \$100 worth of special pupus, also courtesy of Merrel. The number of neighbor island members attending has increased significantly, and we hope this trend will continue.

At its last meeting the HAFP Executive Council voted to nominate **Mary Glover** and **Fred Reppun** for the national Good Housekeeping and AAFP Doctor of the Year award . . . It was also decided to support two state chapters in major lawsuits. Michigan is suing the Feds for dual fee schedules that discriminate against FPs while the Nebraska suit supports a surgeon expelled from ACS for turning post-op care of patients over to FPs, termed "unqualified people" by ACS. Council voted to back up our support with a monetary contribution of \$100 to Michigan and \$50 to Nebraska. Aloha.



HENRY N. YOKOYAMA, M.D.

Murphy's Law 2

(By Arthur Bloch)

SIX PRINCIPLES FOR PATIENTS

1. Just because your doctor has a name for your condition doesn't mean he knows what it is.
2. The more boring and out-of-date the magazines in the waiting room, the longer you will have to wait for your scheduled appointment.
3. Only adults have difficulty with child-proof bottles.
4. You never have the right number of pills left on the last day of a prescription.
5. The pills to be taken with meals will be the least appetizing ones.
6. If your condition seems to be getting better, it's probably because your doctor is getting sick.

Life in These Parts

Penicillin-loving gonorrhea spreading here: VD Control Program director **Ned Wiebenga** reported 110 cases in the three years ending Dec. 31 and already 101 cases this year through

September of a gonococcal strain "that actually gobbles up penicillin" . . . "The more you give them, the more they love it. They actually metabolize it . . . Even when the patient feels better, the microorganisms have taken over like weeds in a cornfield," says Ned . . .

No cases of toxic shock reported here . . . Local physicians are wondering why no cases of TSS have been reported in Hawaii. "Since January, 299 cases of TSS have been reported to CDC, 285 of them in women and 25 deaths . . . About 95 percent of the cases are in young women and occurred during a menstrual period. A few cases were diagnosed in men," says Ned Wiebenga . . .

Ethnic factors in life expectancy: For Hawaii residents, ages 35 to 44, the leading cause of death for men and most women is heart disease . . . For Japanese women, the number one killer is breast cancer and for Filipino women, stroke . . . Japanese women have the highest life expectancy in Hawaii and Hawaiian men have the lowest . . . Ages 25 to 34: Motor vehicle accidents are the number one and suicides are number two. After age 30, heart disease becomes the number one killer of caucasian and Japanese men . . . Ages 35 to 44: Suicide is the highest among caucasian men . . . After age 35, Hawaiians have the highest percentage of deaths from heart disease. Lung cancer and cirrhosis are the more common causes of death for certain ethnic groups . . . Ages 45 to 54: Heart disease is number one in all groups except Japanese women. Stroke is number two for Japanese men and Filipinos. Colorectal and gastric cancers are the top fatal diseases among Japanese. Lung cancer is prevalent among men and Hawaiian women . . . Ages 55 to 64: Ranking behind heart disease are stroke, lung cancer and breast cancer. Diabetes is ranked third among Hawaiians and also prevalent among Japanese and Filipinos. Stomach cancer is a ranking cause of death among Japanese men and Hawaiian women . . . Ages 65 to 74: Heart disease and stroke are the top two

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causes of death through all ethnic groups, but caucasians and Hawaiians have the highest rate of heart disease and Japanese the lowest. Diabetes is a major cause of death for all groups, except for Japanese and caucasian men. (Reported by **Fred-erick Dodge**, medical director of the Waianae Coast Comprehensive Health Center at the Annual HMA meeting)

Countersuit in malpractice case: In 1976, **Stephen Aglinskis** treated an elderly Big Island woman for a fall and found nothing wrong with her. The woman again fell six months later, broke a leg and an arm and sued Aglinskis for malpractice, claiming that the second set of injuries was caused by poor care six months earlier. The suit was tossed out, but Aglinskis and the Hawaii Emergency Physicians sued the woman's lawyer Edwin Smith and the court awarded Stephen \$170,000 . . .

AMA chief discounts surplus doctor forecast: **Robert Hunter**, AMA president said physicians should not be frightened by the recent report of the Graduate Medical Education National Advisory Committee. The report predicts that by 1990, there will be 525,000 active doctors, or 59,000 more than will be needed, and by year 2000, the surplus will grow to 130,000. The report made the following recommendations: 1) An overall reduction of 10% in medical school admissions between 1981 and 1984 . . . 2) A cut in the 4,000 foreign doctors and American graduates of foreign medical schools who enter the US . . . 3) Incentives to new doctors who enter residencies in undersupplied specialties and changes in government and insurance company payments to reward doctors who enter family practice and other primary care specialties or who go to areas with doctor shortages . . . 4) A halt to the training of para-professionals . . .

Honored, Elected & Appointed

The HMA officers recently installed are **Neal Winn**, president; **Ann Catts**, president-elect; **K. Y. Lum**, secretary; and **William Iaconetti**, alternate AMA delegate. **John Newman** was installed Kauai councillor and **Nadine Bruce**, **Thomas Cahill**, **Bernard Fong**, and **Lee Simmons** as Honolulu councillors.

Modest **Robert Millard** was named the "Physician of the Year" for his five decades of work with new immigrants and seamen. It was noted that "his skills and attitude put these foreigners at ease and gave them a feeling of confidence as they entered the United States."

The Hawaii Division, American Cancer Society installed **Carl Boyer, Jr.** president and **John Keenan** vice president . . . The Hawaii Heart Association elected **Douglas Bell** president. Other MD officers include **Richard Mamiya**, VP and board members **Morton Berk**, **Danelo Canete**, **Djon Indra Lim**, **George Rhoads**.

A. Leslie Vaseoncellos was elected a board member of the Portuguese Chamber of Commerce . . . **Robert Nathanson** was elected president of the newly formed Hospice Hawaii, Inc. . . . **Richard Kelley** and **Richard Mamiya** were elected to the board of directors of First Hawaiian Bank . . . **Charles Judd**, **Ernest Scheerer**, **Clifford Straehley** and **John Chalmers** were elected to the Hawaii Medical Library board of governors . . . **Gerrit Ludwig** of Hilo, **Andrew Morgan** and **Harvey Takaki** of Honolulu and **Leonard Kiehm** of Kaneohe recently became Fellows of the American College of Surgeons . . .

Sportsmen

The winners in the annual HMA sporting events were as follows:

Golf:

President's Trophy (low net)—**Edward Kagihara**, Robert Miyamoto Perpetual Trophy (low net)—**Edward Kagihara**, John Felix Perpetual Trophy (low gross)—**Michael Okihiro**, **William Yarbrough** and George Mills Perpetual Trophy for Pharmaceutical Representatives (low net)—**James Asato**.

Table Tennis:

Singles—**Philip McNamee**, Doubles—**Philip McNamee** and **John Spangler**.

Tennis Singles:

Open Division (Finals to be played off between **Gerald Dericks** and **Kenneth Kern**), Novice Division—**Roland Tam** and Over 50 Division—**Ral Raj Mehta**.

Doubles:

Open Division—**Benjamin Chang** and **Gerard Dericks**, Novice Division—**Ronald Peroff** and **Patrick Walsh** and Over 50 Division—**Leabert Fernandez** and **Yutaka Yoshida** (whose combined ages total 140 plus).

Deep Sea Fishing:

No fish caught, hence no winners.

Skin Diving:

Cancelled because of cost and sea-sickness factors . . .

"In the annals of 20th century sports there have been some great match races . . . But the match race of the century could take place right here in Hawaii this December . . . This one will be more along the line of the match between the great Jesse Owens and a quarter horse . . . The contestants: Marco Evoniuk and **Dr Jack Scaff** . . . Who is Marco Evoniuk? He is the Jesse Owens of American race walkers, the winner of the 20-kilometer walk in the U.S. Olympic Trials, earlier this year . . . The big question: Can Jack Scaff run the Honolulu Marathon faster than Marco Evoniuk is able to walk it? Attempting to set up this intriguing match race are **Dr Kent Davenport** and Jim Moberly, both board members of the Honolulu Marathon Association. Scaff is prepared to accept the challenge if the contest can be firmed up early enough to allow him to properly train for it . . . If it comes off, it will be a match between a great heel and toe man and a great healer and tower." (Excerpts from "On Running" by mike tymn, *Advertiser* sports columnist)

"One of the favorites in the 30 km run is **Dr Jim Gallup**, the winner of three of the past four races. The 44-year-old pathologist is a familiar figure to many motorists as he commutes daily between his Kahala home and his Punchbowl office by running along with a ditty bag in hand. One would assume that the primary purpose of the bag is to transport his wallet and a few necessities. However, this is not the case. It is used to carry the items which he finds along the way . . . As I visited with him in his office recently, Gallup opened a large drawer to reveal part of his cache to me. There were assorted wrenches, screwdrivers, nuts, bolts, washers, nails, golf balls, miniature toys, combs, a jar of money. So far in 1980, he has found \$25.83. 'The best place to find money is in the gutters around bars,' he told me. His most valuable find to date is a shark's tooth knife, which he says retails at \$59.95. One of his most unusual finds is a .45 caliber bullet . . . Who said that running doesn't pay?" (Another item from mike tymn's column)

At a Sports Medicine Symposium in August, **Ralph Hale**, Prof of OB Gyn at UH School of Medicine remarked that women athletes have limiting physical characteristics, but they do not get more injuries than their male counterparts . . . He emphasized that we shouldn't let these differences make us consider women as fragile.

Ralph was chairman of the Sports Medicine Committee that studied high school football injuries. Eighteen high schools participated in the study which revealed the following:

Half of all high school football injuries occurred before September in preseason practices, scrimmages and games.

35% of injuries occurred during practice, while 65% occurred during games.

37% of all injuries happened on grass surfaces; 26% happened on artificial turf.

Blocking was the most hazardous activity. 34% of all injuries occurred when blocking. 3% of injuries occurred being blocked. 15% occurred during tackling; 14% when there was running and no contact; 18% occurred when someone was stepped on.

Legs are the most vulnerable; 25% of injuries involve the ankle or the knee.

Hands and fingers suffered in 16% and shoulders in 10%. Back injuries 4% . . .

The 8th annual Honolulu Marathon scheduled for Dec 7

is expected to draw only a few hundred more entries than last year's 8,000 plus. When queried, **Jack Scaff Jr.**, president replied, "We're not interested in growth for the sake of growth. The New York Marathon with its 14,012 starters is the largest, while our goal in Honolulu is to run the best marathon in the country and not to concern ourselves about becoming the biggest . . . I'm very happy with the marathon's present size. Our roads are not able to handle much more than we have now . . ."

The Big Island's first masters run for men and women runners 40 years or older was staged on August 31 as part of Hilo's first Senior Olympics Hawaii. **Andrew Sackett** 65, Hawaii County district health officer was regarded as the favorite in the 60 plus men's division. Several other Big Island doctors were entered including a Kona group led by **Frank Ferren** . . .

Professional Moves

It seems that we have missed a few more announcements from September. Pediatrician (and our skin diving partner from bygone days), **William Moore Jr.** will relocate to Suite 205, Kahala Mall Office Center on Jan. 1. OB Gyn man (and our former tennis partner), **Tom Oshiro** has relocated to Suite 304, Medical Arts Building. Two new cardiologists are in town; **Calvin Wong** has opened at Suite 610, 1441 Kapiolani Blvd. while **Kelvin K. Y. Yee** moved to Suite 339, Professional Center Bldg. On Maui, FP **Ben Azman** has relocated to Whalers Suite, Kaanapali, internist-nephrologist **Steven Moser** has joined the Kaiser-Permanente Medical Care Program at 99 S. Market St., Wailuku and plastic surgeon **Stephen Schlesinger** has opened at Suite No. 300, Kahului Building, Kahului. On Kauai, internist **Thomas Harrison** joined Robert and Linda Weiner in the Kalaheo Clinic.

On to October . . . The following moved into the new St. Francis Medical Office Building: internist **Henry Fong**; plastic surgeon-ENT man **Roland Tam**; internist-hematologist **Fortunato Elizaga**; the Hawaii Neurological Clinic of **Calvin Kam** and **William Won**; and internist-pulmonary disease specialist **Ernie Yim**; and internist-cardiologist **Derek Pang** . . . The Kuakini Medical Plaza at 321 N. Kuakini St. gained two new occupants: thoracic, cardiovascular and general surgeon **Edward Izawa** and GP **Henry Yokoyama** . . . The Honolulu Medical Group gained neurologist **Anthony Mauro** and OB Gyn man **Ken Nakasone** . . . Pediatrician **Kenneth Sui** opened at the Professional Plaza of the Pacific, 1520 Liliha St. and **Doris Jasinski** announced that FP **Helena O'Connor** and DDS **Edward Ha, Jr.** have joined her University Medical Clinic at 1904 University Ave. Internist **Kalani Kobayashi** joined the Chock-Pang Clinic at 1374 Nuuanu Ave. and ophthalmologist **Anthony Martyak** joined the Straub Clinic . . . On Maui, internist-gastroenterologist **Charles Scowcroft** joined the Maui Medical Group at 2180 Main St., Wailuku and FP **Robert Conrad** joined the Waimea Clinic Inc. . . . On the Big Island, FP **James Brand** joined the Kohala Health Center.

Physicians Speak Up

Outspoken marathoner, **John Wagner**, is outraged by political sign waving: "I want to say that I strongly agree with the Big Island police that political sign waving is a potential traffic hazard. When I made a change from a Porsche to a moped, I have found this to be even more of a menace since big cars tend to pay even less attention to a little moped when the streets are lined with pretty girls waving signs . . . Perhaps, on the other hand, my real complaint about sign waving is the fact that being a bachelor for the past five years, for weeks and even months at a time and on all holidays, the first face I have to see in the morning is Ike Sutton's down at the bottom of Pacific Heights Road smiling and waving to me even though I always act like I don't see him. I fully expect next August he will be standing there waving his sign saying: "Happy Birthday, John." (Ed: Poor Ike . . . He tries so hard . . . And we do so admire him for his piquant courage . . .)

Robert Lee Jr. pleaded for the life of the Alexander Young Bldg.: "The existence of the Alexander Young

Building, built at the turn of the century, is threatened with demolition by Northwestern Mutual Life Insurance Company despite the building being on the National Register. The building has touched all walks of life with its many professional and business offices that serve center city. All kamaainas have much nostalgia for the building when it was first built as a hotel. To now raze it and in its place build another tower on Bishop Street is to destroy a link to the past. Northwestern Mutual—Save the Alexander Young."

Our editor, **Harry L. Arnold Jr.** was understandably critical of the FDA: "The Food and Drug Administration is empowered by law to evaluate new drugs with regard to safety and efficacy and approve their manufacture and transportation in interstate commerce . . .

It is not empowered to tell patients what they may take or apply or use, much less to tell physicians what drugs they may use for specific diseases or disorders. The public pronouncements of someone identified as a representative of that agency, in recent days, regarding the application of DMSO to sprains or painful joints, were strictly out of order. He was engaging in gossip, and to dignify his remarks as quasi-official warnings, as was done by the radio and perhaps also the press, was improper.

As an example of why we should not pay any attention to the FDA's pronouncements, take the drug Dapsone. It has been in use for the treatment of leprosy for about 35 years, all over the world. For the past 25 years, also all over the world, it has been in gradually increasing use for a variety of disorders, mostly skin diseases: dermatitis herpetiformis (for which it is the drug of first choice), allergic vasculitis, subcorneal pustular dermatosis, and some others.

The FDA permits and approves it only for the treatment of leprosy—nothing else. They do not permit clofazimine or thalidomide to be shipped and marketed at all, though they

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are indispensable in the management of leprosy and have been used all over the world for that purpose for 15 or 20 years. The implication that American physicians cannot be trusted with these drugs is offensive, and improper. There are many other examples.

The FDA has suggested some 29 new programs for itself to undertake (assuming that it was just starting out, that is) and of these only two were voted as desirable by as many as half of the consumer organizations and professional organizations who were asked to vote on them.

Even this grandiose proposal did not include telling doctors what to give or patients what to take. Let us hope the agency's functions will never be allowed to go that far. The FDA is already a conspicuous example of over-regulation by government."

Visiting Physicians

In August, we were privileged to hear James Cerda from U. of Florida speak on "Dietotherapy of GI Disease" . . . QMC Medical Director **Dennis Meyer** introduced Jim Cerda as being certified in medicine and gastroenterology and who has published extensively in nutrition . . . We do have big 'pukas' in our knowledge on diet . . ." Herein are excerpts from this enlightening lecture:

"It's true that physicians do not have much nutritional training . . . Philip White in JAMA 1961 wrote: 'Over the years, fads on what to eat, what not to eat have enjoyed an almost revered position in the therapy of gastrointestinal disorders.' But physicians use diet to punish patients . . . Here are some dietary restrictions which have been imposed by physicians: 'Bland' . . . 'Sippy' . . . 'Milk and cream' . . . 'Boil and broiled' . . . 'No spice' . . . 'Tasteless' . . . 'No Alcohol' . . . 'No caffeine containing beverages' . . ."

"Milk is the world's worst antacid and cream actually increases acid . . . I don't know how many patients I have hurt with this high cholesterol diet . . . The bland diet was banned in 1972 at the U. of Florida when I got there . . . The 'Sippy' is the world's worst punishment for a hospitalized patient . . ."

"Fiber does not bind bile juice . . . Orange juice Vitamin C is just as bioavailable as synthetic ascorbic acid . . . There are no bonafide cases of food allergy in adults—only in children . . . I don't really know what food allergy is . . ."

Pathogenesis of Diarrhea: 1. Lactose malabsorption 2° intestinal lactose deficiency . . . I'm an expert on lactose malabsorption because I have it . . . If you line our stomachs with milk, you will not get drunk . . . Wrong! You get drunk 1½ hours later . . . Parasites also wipe out the remaining lactose . . . eg, Thai's have no lactose . . .

2) Gluten sensitivity (Celiac Sprue): Genetic disorder . . . The Irish and Jewish are high risk groups . . . Dx by small bowel biopsy . . . Clinical Course of 25 cases of Celiac Sprue: 19 asymptomatic; 6 relapses, 7 malignant lymphomas, 1 gastric CA, 5 progressive liver disease, 1 breast CA . . .

Flatus: I will not use 'flatus' . . . Merriam Webster says 'Fart' . . . So I will talk on 'Farting' . . . Bacterial fermentation cause farting . . . Beans and onions cause farting . . . Dds:

Swallowed Air: (2-3.5 L; N2 80% O2 20%) Flatus: (0.2-3.7 L; N2 17-88% CO2 5-80% O2 0-10%)

Food Allergy (In children): Esp. milk, nuts, fish, citrus, eggs, chocolates, peas, wheat, berries and corn . . .

Low Bulk Diets: means low roughage diet . . .

Dumping Syndrome: Treat with frequent meals . . .

Acid-Peptic Disorders ("Heartburn"): Symptomatic reflux . . . No anticholinergic drugs should be used . . . Chocolate and milk affect sphincters . . . Coffee and decaffeinated don't affect the sphincter, but affect acidity.

High Residue Diet: "A good reliable set of bowels is worth more to a man than a good set of brains."

Dietary fiber modifies: fecal output, fecal viscosity, fecal transit, flatus, bacterial flora, bacterial metabolism, bile salt excretion, and fecal excretion of short chain fatty acids . . .

Our "Angels"

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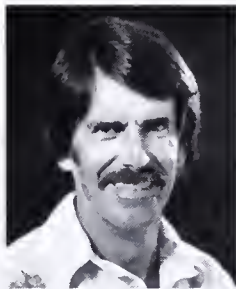
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From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

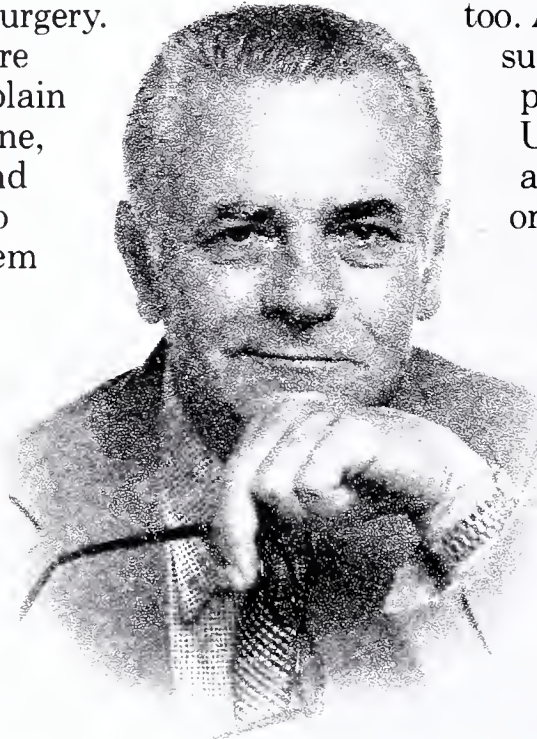
To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk

about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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HMSA Utilization Review Department
Ph: 944-2355



DECEMBER 1980
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Hawaii Medical Journal

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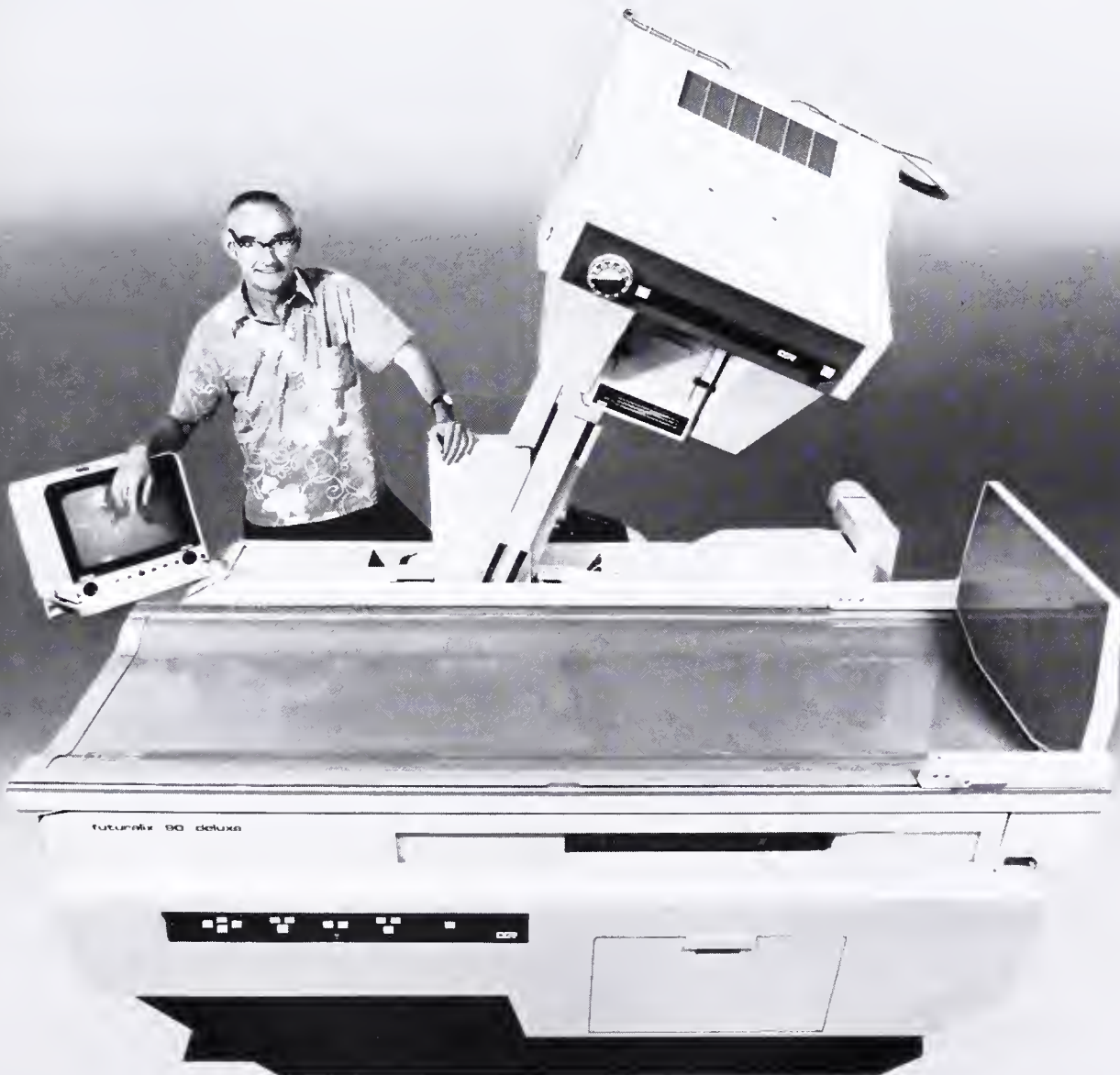
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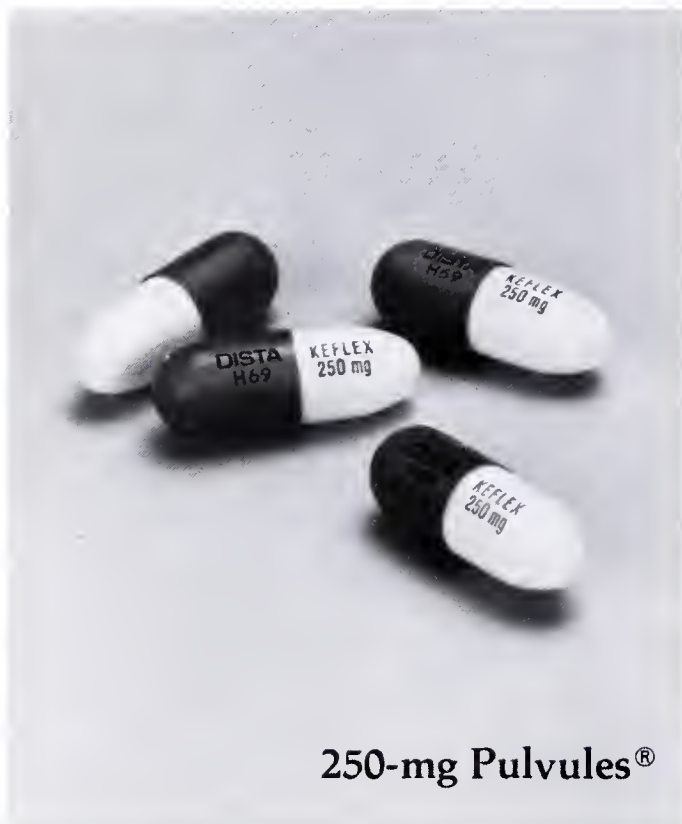
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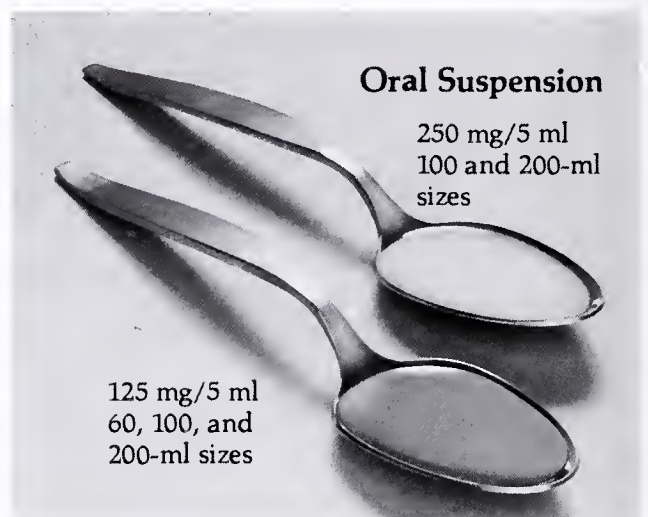
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Noise-Induced Hearing Loss in Aviators

CASIMER JASINSKI, M.D. *Honolulu**

When the Industrial Revolution was in its infancy 150 years ago, almost no attention was directed toward controlling hazardous noises, primarily because little was known about what damage noise could do. Factory workers were exposed to extremes of cold, heat, poor lighting, air and noise pollution, among the occupational stresses associated with developing production line techniques.

As technology moved onward, enlightened preventive occupational health programs were instituted, and many of the sweat shops were drastically reduced. Each injury or disease that seemed to be job-connected came to be carefully studied and corrective measures applied.

With increased power requirements of larger and faster machines, noise increased proportionately. Extreme examples of this are in jet aircraft and rocket propulsion connected with military and space programs. Recently, electronic amplification of "rock and roll" music has been found to cause damage to the hearing mechanism.¹

The U.S. government conducts probably the most comprehensive hearing conservation program in the world. The purpose is twofold: (1) to conserve the hearing of all military and civilian personnel routinely exposed to noise, and (2) to insure continued retention and utilization of skilled and valuable personnel, who might otherwise have to be retired prematurely because of hearing loss arising from work trauma.

Recently, industry has had to comply with new legislation such as the Walsh-Healey Public

Contracts Act, which compels manufacturers to protect the hearing of their employees if they deal with the Federal government or take part in interstate commerce.

Many municipalities in the United States have tried to modify the problem of damaging noise by adopting ordinances regulating the noise level in neighborhoods. Penalties ranging from \$25 to \$500 or 60 days in jail may be imposed on violators who exceed the imposed sound levels.²

The principal reason for this increased interest in noise is its inherent property of causing not only discomfort and fatigue but also the dreaded progressive "sensorineural hearing loss." At first, such loss is mild and temporary, but with continued exposure to high noise levels, hearing loss becomes permanent and relatively unresponsive to surgical or medical treatment.³ The only effective management of the problem of sensorineural hearing loss appears to be primary prevention.

Noise-induced hearing loss (NIHL) is a disability not readily recognized, as the defect is not visible. This type of crippling is seldom sudden or dramatic in onset, requiring from 5 to 15 years of industrial noise exposure before the earliest indications are recognized by audiometric testing techniques.⁴ However, the individual who sustains such gradual hearing damage ultimately finds a world of lonely silence and may seek restitution through legal channels. Compensation laws are very liberal in certain states, making NIHL of major concern to managers.

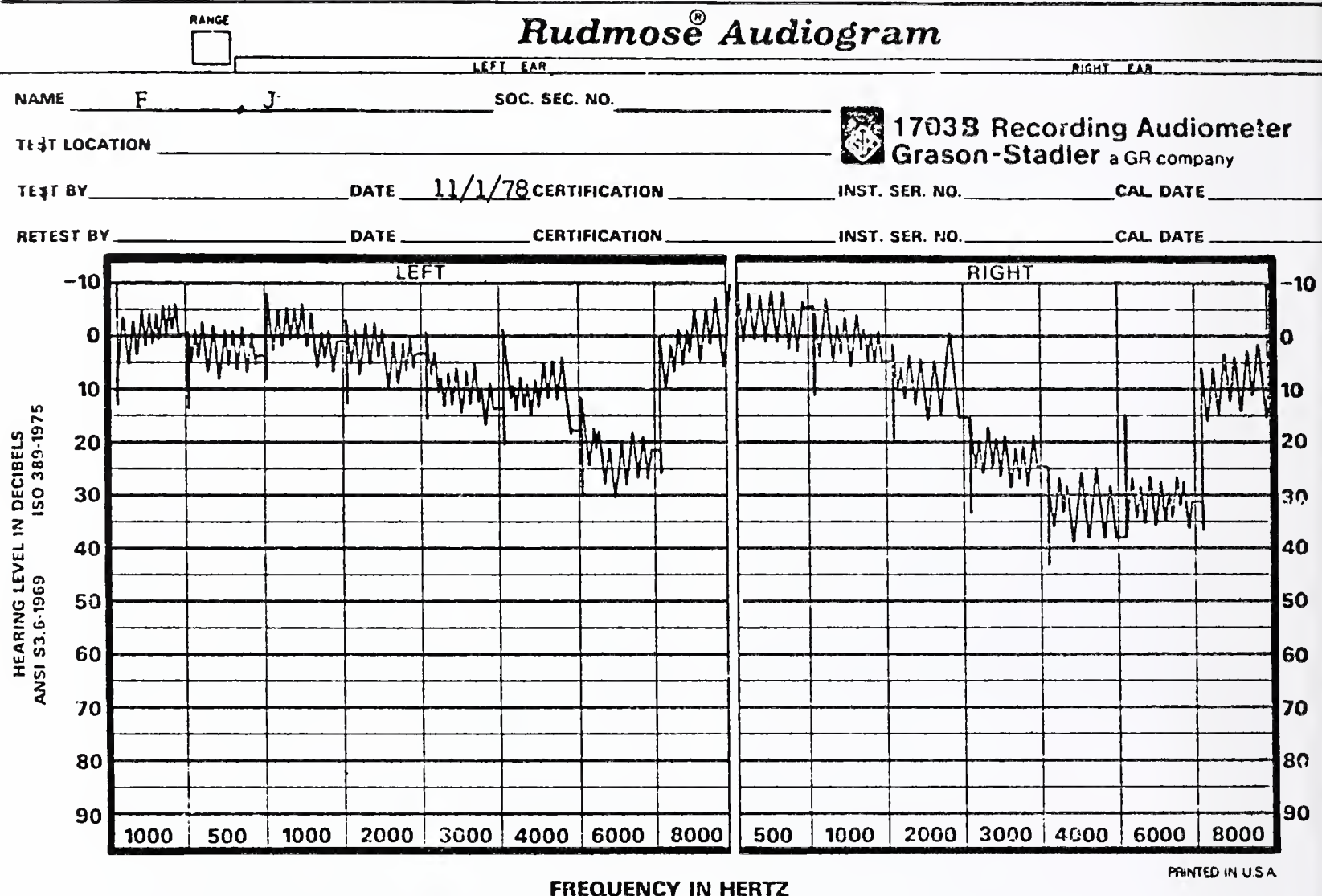
Aircraft Noise

This paper concerns the incidence of hearing loss in a large government industry where noise

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FIG. 1.—Example of high-frequency hearing loss in a pilot, as seen on Rudmose Audiogram.



exposure, mainly from aircraft, is a common and, to some degree, unavoidable environmental hazard. Recent surveys estimate that approximately 10% of the U.S. population has significant hearing loss. Sataloff feels that 20 to 25% of newly hired employees in industry have some significant hearing loss.⁵

Since the flying business is demanding, high initial criteria do not permit handicapped persons ready entry. In effect, student pilots and others associated with aviation are a relatively healthy group without significant hearing loss problems. However, a pilot may fly with significant hearing loss (and even hearing aid), with appropriate waiver, after a particular problem has been sufficiently studied and the condition has been found to be compatible with safe flying.

Data Presented

The data on hearing loss presented in this report are on 100 audiograms. These are unselected, in that the medical records from which they were taken were pulled from files of airmen, air traffic control specialists and other aviation personnel, all personally examined by the author during a 3-month period. Over 70% had significant noise exposure as part of their occupational environmental background. Women were

excluded from the study group, since they seem to be more resistant to noise-induced hearing loss and too few were examined during this period.

The purpose was to analyse hearing loss detected in 100 automatic Rudmose audiograms (Fig. 1), to determine the degree and the type of hearing loss present, and to relate this to a number of variables such as age, occupation and flying hours. Since acoustic trauma is the most likely cause of hearing loss in industry where high intensity noise exposure is commonplace, this will be the principal consideration in relating the degree of hearing loss. If the pattern analysis of any audiogram very obviously did not fit the criteria of the hearing loss pattern,⁶ it was removed from the series in an effort to present a true picture of the cross-section of an aviation industrial population and the degrees of acquired hearing loss (if any) from the industrial noise exposure.⁷

The subjects in this study were primarily visitors and employees of the Federal Aviation Administration, seeking a medical service from the Aviation Medical Division or the Regional Flight Surgeon during a 10-week period. A few cases were taken from a group of patients seen at the Hawaii Air National Guard. The subjects included pilots and other aircrew, air traffic con-

trollers, executives, electronic technicians, automobile drivers, laborers, and a wide variety of non-federal civilian workers exposed to aircraft noise. The unselected files of all FAA pilots in this region were pulled and made a part of the 100 audiograms. To complete the series of 100 audiograms, unselected records of the Pacific regions's air traffic control specialists were added.

Results and Discussion

The Chi-square statistical analysis of the audiogram tables was significant only in a spotty fashion indicating better hearing in the younger pilots and an increased occurrence of hearing loss in the 56 to 76 plus DB group of the older non-pilots. The implications of these results are obscure.

Further re-grouping of subjects into non-exposed or minimally noise exposed and more highly exposed individuals netted interesting results. Comparison of subjects who were highly exposed to noise with those minimally exposed were analysed by Chi-square. Increased occurrence of hearing loss was found at levels of 66 to 76+ DB in the highly exposed group.

The third tabulation in this series compared occurrence of hearing levels of only the severely exposed 45-to-54-year-old group to expected occurrence found in the National Health Survey (NHS)⁸. The Chi-square for the group was not significant at the .05 level. However, subgroups were found to be statistically significant at the .05 level in the 4,000 Hz and 6,000 Hz. This was in the upper hearing loss groups of 36 to 65 DB ranges, indicating that aviators' noise exposure must be in excess of about 4,000 hours of logged pilot time to bring on the earliest signs of hearing impairment. This impairment in its earliest phase is confined to the higher (non-speech) frequencies and manifests itself by an increased occurrence of pilots with hearing levels from 36 DB

to 76+ DB in the 4,000 Hz and 6,000 Hz pitch frequencies. The average logged pilot time in the highly exposed group was 8,500 hrs. and ranged from a low 4,000 hours to a high of 22,000 hours. This indicates that, even with considerable exposure, in terms of noise intensity and length of exposure, the earliest signs of hearing damage are minimal; only a small group is affected. Further, the damage is insignificant, because only high frequency reception is involved, the important speech frequencies (500-2,000 Hz) being spared.

Summary and Conclusions

Analysis of 100 automatic Rudmose audiograms (45 in pilots and 55 in non-pilots), taken at the F.A.A. Honolulu Aviation Medical Division, were analysed and compared to data derived from the National Hearing Loss Survey of 1960-1962. An attempt was made to show a dose/response relationship between hours of noise exposure and the earliest signs of permanent hearing loss as seen in the audiogram tracings given at annual exams.

Results indicated that pilots as an occupational group showed no statistically significant increased hearing loss as compared to non-pilots of comparable age groups. This study does, however, show a very slight decrease in high frequency hearing at 4,000 Hz and 6,000 Hz after an accumulation of approximately 8,500 hours of flying time. This exposure usually averages 90 to 110 DB of noise in or near the aircraft, regarded as a damaging level.⁷ This accumulation of flying hours usually requires well over 10 years of flying duty, and the hearing loss does not become manifest until age 45 to 55 years. Earliest sign of this loss is in the increased occurrence of hearing loss at the 40 to 80 DB range in the 4,000 and 6,000 Hz frequency.

REFERENCES

1. Smitley, E. K. et al *Arch of Envir Health* 22:413-420, 1971.
2. Meade, J. P. "Noise," *Aerospace Safety*, April 1971.
3. Von Bekisy, G. Personal Communication, 1971.
4. Glorig, A. et al *Arch of Otolary* 74:418, 1961.
5. Sataloff, J., Ed *Industrial Deafness*: New York. McGraw-Hill Book Company, 1957.
6. Ward, W. D., Symposium on Hearing Loss. *Otolary Clinics of North America*, February 1969.
7. Kryter, K. D. et al, *Journal of Acoust Soc America* 39:451, 1966.
8. Hearing Levels of Adults by Age and Sex, USA. National Health Survey U.S. Printing Office. 1960-1962.



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Noise: A Slow Accident

JOHN LEOPOLD, *Honolulu**

In October, 1953, an employee of the Green Bay Drop Forge Company in Green Bay, Wisconsin, won a court-ordered claim for compensation for a hearing loss which the employee attributed to noise at his work site. It was one of the earliest legal cases involving liability for loss of hearing due to industrial noise. Now, we are on the threshold of a surge of litigation and workmen's compensation claims for hearing damage due to noise in the workplace. Unfortunately, governmental agencies, most employers and labor unions and the community at large have not yet demonstrated the strong resolve necessary to forestall the impending problem.

HSPA Hearing Tests

Notable efforts have been made in Hawaii to control and protect workers from excessive noise, such as the initiative taken 3 years ago by the Hawaiian Sugar Planters' Association to establish a hearing conservation program that includes pre-employment and annual hearing tests and strong enforcement procedures. However, the inequitable danger is that workplace hearing loss claims will be made without consideration as to how much of that hearing loss is attributable to aging or normal hearing loss or to noise outside the workplace. Employers and the State Workmen's Compensation Fund clearly should not be targets for claimants whose hearing loss is due, in significant measure, to excessive noise in their home or recreation environment. Federal Occupational Safety and Health Administration laws, as well as standards set by our State Labor Department's Occupational Safety and Health Division, which assumed responsibility for most of Hawaii's safety enforcement from OSHA in 1975, are based on the premise that, after the worker's noise exposure at work, the rest of his or her time is spent in quiet.

In this era of "the noise generation," with its discos, dirt bikes, dune buggies, rock concerts

and motorboats, this premise is no longer valid, if, in fact, it ever was. Audiologists today are finding more and more teenagers with serious hearing problems, caused not by factory noise, but by exposure to loud noises, often rock music, in their home and recreation environments.

Noise in the Workplace

Obviously, in many cases, it would be highly dubious for an employee to claim that his hearing loss was entirely the fault of his employment. Employers, in fact, will now have to make an effort to keep (as part of an employee's personnel file) a record of the kind of noise exposure an employee experiences outside the workplace. This has become necessary because even pre-employment hearing testing, which establishes a base line of hearing proficiency, cannot separate out the noise-induced hearing loss outside the workplace, which contribute to the worker's total hearing loss over a period of years.

Noise in the workplace could accurately be described as a "slow accident," and the health effects of exposure to excessive levels of industrial noise are serious. Although the Federal allowable industrial noise level is 90 decibels for 8 continuous hours, researchers have found that hearing loss and health damage will occur at the 70-decibel level. Excessive noise wears out the nerve cells of the inner ear, and if the exposure is prolonged, noise destroys the cells, and the hearing loss becomes permanent.

Hearing loss is not the only negative health effect that workers suffer from noise. Noise creates stress, which causes blood vessels to constrict. Pulse rate, blood pressure, and breathing rate increase, and there are marked changes in blood chemistry. A German study has documented a higher rate of heart disease in noisy industries, and in Sweden, several researchers have noted more cases of high blood pressure among workers exposed to high levels of noise.

In addition to heart disease problems, the increased flow of adrenalin and other hormones

*Former State Senator

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makes workers prime candidates for illnesses caused by stress. Leonard Woodcock, former President of the United Auto Workers, has said that the auto workers "find themselves unusually fatigued at the end of the day compared to their fellow workers who are not exposed to much noise. They complain of headaches and inability to sleep, and they suffer from anxiety, and tell us the continuous exposure to high levels of noise makes them tense, irritable and upset."

Noise can also interfere with work. It causes errors in people's observation and leads to breaks in concentration, sometimes followed by changes in work rate. Research studies have confirmed that noise exposure can cause exhaustion, absentmindedness, mental strain, and absenteeism, all of which increase the risks of accidents and injuries. Both excessive noise and a worker's poor hearing can cause warnings of impending danger, as well as cries for help, to go unheeded.

Tractor Noise

Several years ago in Hawaii, several sugar plantations were cited by the State for loud tractor noise, and both engineering and administrative controls were recommended as solutions. Both proved ineffective and economically infeasible. Putting a \$15,000 cab on each tractor could not only have put the sugar industry out of business, but also was found to reduce the noise level at the driver's seat by only 2 to 3 decibels. The administrative control of shifting workers every hour on the tractors would also have proved economically unjustifiable. The solution, which reduced the noise level by 30 to 40 decibels, was the use of hearing protectors worn over the ears. The citing of the sugar companies

by the State for excessive noise led to the creation of a hearing conservation program by the HSPA.

Unfortunately, in spite of extensive educational efforts which have pointed out the many physiological and psychological problems resulting from excessive noise, there is still a great need for a more serious attitude on the part of government officials who are charged with the responsibility of enforcing noise laws and regulations. Although the Hawaii State Department of Health has 10½ positions for noise control, and numerous noise complaints have been received by the Honolulu Police Department, noise violations are generally not regarded by enforcement personnel and their supervisors as a serious problem.

Noise will not be considered a serious problem in Hawaii until there is a public constituency large enough and vocal enough to have an impact on the decision-makers holding public office. Last year, for example, the Noise and Radiation Section of the State Health Department agreed to conduct an educational program regarding noise control and the use of noise level meters for the Honolulu Police Department, but the Police Department reportedly had no interest in attending the session, and the Department of Health program was canceled.

There must be a joint effort by employers, labor unions and State and county elected officials to quiet our community. All have a stake in accelerating an educational effort regarding the health hazards of excessive noise. A quiet community is usually a safe community, and the citizens of Hawaii should not wait for a flood of noise-induced workmen's compensation claims to demand a quiet, safe environment, both at home and at work.

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Maladie du Jour

One of the latest regulatory absurdities involves the Small Business Investment Act of 1978 (PL 95-507), which requires organizations receiving Federal grants to establish Small Business (SB) and Small Disadvantaged Business (SDB) Subcontracting Plans, to verify dollars spent with SBs and SDBs.

The laudable purpose is to assure sharing of Federal funds by needy small businesses. But like countless other laws, PL 95-507 provides an example of how good ideas go awry in the hands of regulators.

The experience of the Pacific Health Research Institute (PHRI) proves instructive. PHRI receives a grant for "Long Term Follow Up of Breast Cancer Screening Participants," and must submit an acceptable SB and SDB Subcontracting Plan detailing its purchases from small business vendors, or lose all funding.

Unfortunately the local Small Business Administration (SBA) doesn't have any list of what it considers an SB or SDB. This means that PHRI's prospective vendors must first seek a ruling by the SBA then, if accepted, they must self-certify their approval. PHRI purchases must first be screened for price and quality, then for SB and SDB qualifications of the vendor. If a prospective vendor fails to qualify, PHRI must return to the next-best price and quality vendor to determine its SBA qualifications, etc.

Compliance with the complex regulation, PHRI learned, including documentation of goals, standards, conformance, equitable opportunities, auditing, updating and revising would cost \$63,000 for the 5 year grant.

PHRI appealed to the SBA that their labor-intensive institute spends only \$12,500 annually with small businesses, and that the taxpayers would be paying another \$12,500 a year merely for documentation of the amount which would go to SBs anyway. The SBA seemed unconcerned about this waste, and refused an exemption. "Sorry, regulations."

PHRI next questioned the wisdom of restricting procurement to SBs and SDBs regardless of price, and warned of the danger of accepting lesser quality merely for the purpose of achieving goals. "Regulations. Sorry."

Finally, PHRI appealed on the basis that small businesses are themselves exempt from these onerous regulations. The SBA agreed but, alas, businesses are defined as "profit making," so small non-profit institutes can hardly expect to qualify for this small business exemption. "Sorry!"

So next year PHRI will spend \$12,500 with small businesses, as always, but now the National Institutes of Health will provide an extra \$12,500 annually to document these purchases. Thus, the government will pay the bill for compliance with government regulations. (Then *you'll* pay the government's bill.)

Having exhausted appeals for an exemption, Director Fred I. Gilbert, Jr., M.D. is philosophical: "Ironically, our Institute qualifies as Small and Disadvantaged, yet we are penalized and placed at a further disadvantage by enforced compliance with regulations which prove utterly wasteful in cases such as ours. To require spending a dollar on paperwork for every dollar spent on purchases breeds contempt for the entire bureaucracy. These rules simply *must* be revised to achieve their real purpose, but no one in Washington seems able to save us from those who, with all intent to do good for a few, end up doing harm to us all."

Well-intended laws commonly spawn a maze of regulations, which in turn generate compliance costs which are frequently unjustifiable in terms of their intended benefits. These unproductive expenses are defended because regulations mandate them, are rationalized because the government covers the costs, and are overlooked because the ultimate payee remains ignorant of the misspending of his money.

When a regulatory system proves consistently unable to respond to its demonstrated incongruities, or to correct its proven errors, the risks to society grow so great as to nullify potential benefits. The entire regulatory machine must be dismantled.

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William Dang (1980)
William Iaconetti (Maui) (1980)
Richard Omura (1980)
Herbert Chinn (1981)
William Hindle (1981)
Winfred Lee (1981)
Sakae Uehara (1981)
Ann Catts (1982)
John Kim (1982)
George Mills (1982)
Henry Oyama (1982)

Bylaws and Parliamentary

Gladys C. Fryer, Chairman
K. Y. Lum, Commissioner
Harry Arnold
Robert Clingan

Cancer Commission

Drake Will, Chairman (1982)
Grover Batten (1980)
Carl Boyer (1982)
Thomas Burch, ex-officio
John Chalmers (1982)
Reuben Guerrero (1981)
Thomas Hall (1981)
Noboru Oishi (1980)
Verne Waite (1981)

Cancer Committee

John Keenan, Chairman
Thomas Cahill, Commissioner
Grover Batten
Richard Blaisdell
Carl Boyer
Vincent Brown
Thomas Burch
Ann Catts
Nathaniel Ching
Paul DeMare
Fortunato Elizaga
Norman Goldstein
Reuben Guerrero
Thomas Hall
Philip Hellreich
M. Ward Hinds
Reginald Ho
Robert Jim
Elmer Johnson
Laurence Kolonel
Thomas Lau
Kevin Loh
James Lumeng
Noboru Oishi
Young Paik
Niranjan Rajdev
Kleona Rigney
John Spangler
Robert Wilkinson

Manas Ghosh (Hawaii)
DeWitt Smith (Hawaii)
James Williams (Hawaii)
Jose Romero (Maui)
John Withers (Maui)

Child Health Planning, ad hoc

Calvin Sia, Chairman
Elizabeth Adams
Jeanette Chang
Victor Ho
Y. Edward Hsia
Roy Smith
Ruth Matsuura (Hawaii)
W. Y. Buchanan
David Wood

Chronic Illness

Gladys Fryer, Chairman
Thomas Cahill, Commissioner
Clagett Beck
Martha Helley
Willard Miyahira
Shozo Ogawa
James Musgrave
Walter Quisenberry
Kleona Rigney
Adela Sanidad
Verne Waite
Peter Kim (Kauai)
A. Scott Miles (Hawaii)
Burt Wade (Hawaii)
R. P. Wipperman (Hawaii)

Communicable Disease

Francis Pien, Chairman
Thomas Cahill, Commissioner
Donald Char
Amelia Jacang
James Lumeng
John Peyton
Lawrence Winter
Dennis Fu (Maui)
Katok Chuang (Kauai)
Welman Shrader (Hawaii)
Frederic MacInnes (Hawaii)

Community Health Care

Robert Kistner, Chairman
Donald Char, Commissioner
James Bennett
Carl Boyer
Kenneal Chun
Gladys Fryer
Fred Gilbert
Kim Goh
Armand Hernandez
James Lumeng

Paul McCallin
George Mills
Alan C. Nelsen
Noboru Oishi
George Schnack
Calvin Sia
Fay Weinstein
Mark Wentworth (Hawaii)
Katok Chuang (Kauai)
Arch Wigle (Hawaii)

Convention

Herbert Uemura, Chairman

Crippled Children

D. Vehudhar Reddy, Chairman
Thomas Cahill, Commissioner
Stanford Au
Kenneal Chun
Stanley Chung
Y. Edward Hsia
Katsuji Kubo
Jordan Popper
Pauline Stitt
Ramon Sy
Thomas Walinski
Katok Chuang (Kauai)
Denis Fu (Maui)
Reginald Carvalho (Hawaii)

Disaster

Leonard Howard, Chairman
Donald Char, Commissioner
Francis Au
Joseline Brestle
Casimer Jasinski
Robert Lindberg
Edmund Lum
Michael McCabe
Deborah Putnam
David Eith
Ulrich Stams
James Matayoshi (Hawaii)
Andrew Sackett (Hawaii)
Burt Wade (Hawaii)

Economic Evaluation & Adjustment

Douglas B. Bell, II, Chairman
George Goto
William Hindle
K. Y. Lum
Neal Winn

Emergency Medical Services

Stanley Saiki, Chairman
John Chalmers (DOH)
Herbert Chinn
William Dang (ex-officio)
Douglas Ostman

Fee Survey

Maurice Nicholson, Chairman
William Dang, Commissioner
Thomas Cahill
Kenneal Chun
John Corboy
Raymond DeHay
Gunther Hintz
Allan Izumi
Calvin Kam
George Kenessey
David Kimura
Rowlin Lichter

Carl Lum
Thomas Maeda, Jr.
Eugene Magnier
Michael McCabe
L. Q. Pang
E. Lee Simmons
Donald Sroat
Ramon Sy
Thomas Teruya
Hamilton Winston
Dan Yoshioka
Walter Young

Finance

William Hindle, Chairman
Nadine Bruce
Winfred Chang
William Dang
Henry Fong
Elmer Johnson
Ronald Peroff
Ung Lee (Hawaii)
John Newman (Kauai)
Michael Savona (Maui)

Health Care Costs

Marion Hanlon, Chairman
Donald Char, Commissioner
Raymond DeHay
Charles Judd
Calvin Kam
Paul McCallin
George Mills
Alan C. Nelsen
Benjamin Tom
Dan Yoshioka
Timothy Oldwater (Hawaii)

Health Manpower

George Bolian, Chairman
Donald Char, Commissioner
Richard Blaisdell
Thomas Cahill
Ann Catts
H. H. Chun
Gary Edwards
Ralph Hale
Sherrel Hammer
Charles Judd
Kevin Loh
K. Y. Lum
George Mills
Alan C. Nelsen
George Schnack
Steven Wallach
Donna McCleary (Maui)
Welman Shrader (Hawaii)

Jail Health Care, ad hoc

Walter W. Y. Chang, Chairman
Nadine Bruce
Albert Chun-Hoon
James Lumeng
Neal Winn

Leadership Conference

Douglas B. Bell, II, Chairman
Ann Catts
Albert Chun-Hoon
William Dang
George Goto
William Hindle
K. Y. Lum
Calvin Sia
Neal Winn

Legislation

George Goto, Chairman and Commissioner
Richard Blaisdell
Frank Ceccarelli
John Chalmers
Robert Clingan
Richard Fardal
Philip Hellreich
Gerald Hiatt
William Hindle
Leonard Howard
Kenneth Hughes
Roy Kuboyama
Robert Lindberg
Laurence McCarthy
Walter Quisenberry
George Schnack
Calvin Sia
E. Lee Simmons
Charles Yamashiro
Robert Aikman (Hawaii)
Russell Stodd (Maui)

Maternal and Perinatal Mortality Study

Lockwood Young, Chairman
Ann B. Catts, Commissioner
Robert Allin
Elenita Alvarez
Mario Bautista
Ronald Berman
Rodney Boychuk
Thomas Burch
Alan Chang
James Drorbaugh
David Easa
Gary Fujimoto
Steven Golde
George Goto
William Hindle
Clayton Honbo
Leonard Howard
Y. E. Hsia
Gordon Ing
Gail Li
Michael Light
Paul McCallin
Wayne McKinny
Richard Mitsunaga
Carl Morton
Herbert Nakata
Shigeo Natori
Roy Niimi
John Ohtani
Gordon Ontai
Thomas Oshiro
Gary Pettett
Kathleen Poon
D. Venudhar Reddy
Richard Sakimoto
Walton Shim
George Shimomura
Roy Smith
John Spangler
Wayne Takemoto
Thomas Teruya
Elbert Tomai
Herbert Uemura
James Wong
Franklin Young
Joseph Young
Robert Aikman (Hawaii)
Richard Lundborg (Hawaii)
James Phillips (Hawaii)
Patrick Aiu (Kauai)
Katok Chuang (Kauai)
Denis Fu (Maui)

Wolfgang Pfaltzer (Maui)
Donna McCleary (Maui)

Medical Ethical, Moral, and Legal Concerns

Ann Catts, Chairman
Paul DeMare
Fortunato Elizaga
Gladys Fryer
Mary Glover
William Goebert
Kenneth Hughes
Charles Judd
Herbert Nakata
Jordan Popper
Arnold Siemsen
Raymond Taniguchi
Thomas Whelan
Donna McCleary (Maui)
DeWitt Smith (Hawaii)

Medicaid, ad hoc

E. Lee Simmons, Chairman
Thomas Cahill
George Kenessey
Philip Hellreich
David Kimura
Roy Kuboyama
Worldster Lee
Maurice Nicholson
L. Q. Pang
Young Paik
Adela Sanidad
James Tsuji
Walter Watt
Mark Wentworth (Kauai)
Ben Hur (Hawaii)

Medical Education

Nadine Bruce, Chairman and Commissioner
Elenita Alvarez
Norberto Baysa
Ann Catts
Donald Char
Jeanette Chang
Ralph Hale
Russell Hicks
William Hindle
Edgar Ho
Azucena Ignacio
Gordon Ing
John Kim
Roy Kuboyama
Sigdian Lim
Bal Raj Mehta
Noboru Oishi
James Orbison
Young Paik
Ramon Sy
Benjamin Tom
Patrick Walsh
John Watson
Thomas Whelan
Gilbert Yamamoto
Douglas Bell, ex-officio
Delia Chang
Lynn Rayner
Jose Romero (Maui)
Manas Ghosh (Hawaii)
Robert Schmidt (Kauai)

Medical Malpractice Insurance Law, ad hoc

Philip Hellreich, Chairman
Frank Ceccarelli

William Goebert
Kenneth Hughes
R. Bruce Joseph
David Kimura
Worldster Lee
Richard Siegel
Marquis Stevens
James Phillips (Hawaii)

Nominating

William W. L. Dang, Chairman
Ann Catts
George Goto
Andrew Morgan
E. Lee Simmons
Arch Wigle (Hawaii)
Denis Fu (Maui)
Yonemichi Miyashiro (Kauai)

Peer Review

Ann Catts, Chairman and Commissioner
Claude Caver
Malcolm Ing
Calvin Kam
Alan Hawk
Gail Li
Noboru Oishi
William Sage
George Schnack
E. Lee Simmons
Benjamin Tom
Dan Yoshioka
Minolu Cheng (Hawaii)
Peter Kim (Kauai)
Donna McCleary (Maui)
Burt Wade (Kauai)

Public Affairs

Gerald Hiatt, Chairman
Philip McNamee, Commissioner
Robert Clingan
Charlotte Florine
Norman Goldstein
William Holmes
Virgil Jobe
Christopher Marsh
George Schnack
Robert Schulz
Henry Yokoyama
Russell Stodd (Maui)

Public Safety

Truett Bennett, Chairman
Thomas Cahill, Commissioner
Michael Dimitrion
Lawrence Lau
Michael McCabe
Gary Nishida
Kleona Rigney
John Spangler
Pete Okumoto (Hawaii)

Publications

Doris Jasinski, Chairman
K. Y. Lum, Commissioner
Harry Arnold
John Corboy
Charlotte Florine
James Lumeng
William Moore
Michael Okihiro
Henry Yokoyama

School Health

Ann Ho Yee, Chairman
Thomas Cahill, Commissioner
W. Y. Buchanan
Donald Char
L. T. Chun
Michael Hase
Russell Hicks
Amelia Jacang
Worldster Lee
William McKenzie
James Mertz
James Musgrave
John Peyton
Calvin Sia
Pauline Stitt
Thomas Walinski
Carolina Wong
David Wood
Mark Wentworth (Kauai)
Katok Chuang (Kauai)
Ruth Oda (Hawaii)

Self-Insurance, ad hoc

John Edwards, Chairman
Herbert Chinn
Albert Chun-Hoon
William Dang
George Ewing
Bernard Fong
George Goto
Elmer Johnson
R. Bruce Joseph
Gail Li
Gabriel Ma
Maurice Nicholson
L. Q. Pang
Alexander Roth
Calvin Sia
Robert Simmons
Neal Winn
Sakae Uehara (Maui)

Special Program Arrangements

Herbert Chinn, Chairman

Sports Medicine

Bal Raj Mehta, Chairman
Thomas Cahill, Commissioner
James Bennett
Kent Davenport
Gary Edwards
Russell Hicks
David Kimura
Gerald Mayfield
William McKenzie
George Mills
Ichiro Nadamoto
Robert Nemechek
Ronald Peroff
Allen B. Richardson
Patrick Walsh
Richard You
Walter Loo (Hawaii)
Pete Okumoto (Hawaii)
C. E. Probst (Maui)

State Medical Examiner System, ad hoc

George Goto, Chairman
John Hardman
Laurence McCarthy
Paul Tamura
John Wellington
Drake Will

Substance Abuse/Pharmacy

James Lumeng, Chairman
Thomas Cahill, Commissioner
Vincent Aoki
Robert Bjornson
John Chalmers
Bernice Coleman
Edwin Curphey
Gladys Fryer
Russell Hicks
Walter Watt
David Wood
E. M. Montell (Hawaii)
Edward Underwood (Maui)

Tel-Med

Philip McNamee, Commissioner
Gerald Hiatt
Rowlin Lichter

TV-Radio

John Corboy, Chairman
Philip McNamee, Commissioner
Malcolm Ing
John Keenan
Michael McCabe
Robert Schulz
Douglas Bell, ex-officio

Workers Compensation

Robert Clingan, Chairman
William Dang, Commissioner

Francis Au
Clifford Chock
Albert Chun-Hoon
Raymond Dusendschon
David Eith
Casimer Jasinski
David Kimura
Rowlin Lichter
Herbert Luke
Gary McQueen
Maurice Nicholson
Bernard Scherman
E. Lee Simmons
Dan Yoshioka
Edward Underwood (Maui)

PROCEEDINGS OF THE HOUSE OF DELEGATES

124th Annual Meeting of the Hawaii Medical Association

Reference Committee on Public Health and Education

AMA Delegate

ACTION: Approved.

This is a short report on the major actions taken by the AMA House of Delegates at its Annual Meeting on July 20-24, 1980. For a more complete summary, I urge you to read the American Medical News of August 1/8, 1980, which reviewed a lot of the important actions taken by the AMA House of Delegates.

With 279 delegates, this was the largest House in the history of the Association. Although the American College of Surgeons had withdrawn its representation, the House voted to keep the seat open in the hopes that ACS would reconsider. In another action, the House voted to terminate representation from the Canal Zone since it no longer meets the criteria for a constituent society.

It was a busy meeting with the House acting on 249 resolutions and reports pertaining to virtually every interest and concern of the practicing physician.

The best news was an item omitted from the agenda at this meeting—a dues increase. We had thought that we would be considering a dues increase but the financial strength of the Association is such that action on a dues increase was postponed. However, there are economic indications that there will be action on a dues increase at the 1981 Annual Meeting for implementation in 1982. Major issues before the House included:

- A revision of the Principles of Medical Ethics
- JCAH standards for hospital accreditation
- Medical education accreditation
- An important study of Health Maintenance Organizations
- National Health Insurance
- A question of the proper role of the physician in executions
- Membership
- Chiropractic

Principles of Medical Ethics

By more than a two-thirds vote, we adopted a revised version of the Principles of Medical Ethics proposed by an ad hoc committee of the House. After two years of study and consultation with medical societies and individuals, the committee submitted a revision consisting of a preamble and seven sections. The Principles were last revised in 1957, 23 years ago. This was the fifth revision. Long, hard arguments

The first session of the House of Delegates was called to order by President Douglas B. Bell, II on Monday, October 13, 1980, at 1:30 p.m., in the Ahi Ballroom of the Pacific Beach Hotel. Dr. Kwong Yen Lum, Secretary, called the roll. Present were: Drs. Douglas B. Bell, II, Neal Winn, George Goto, Kwong Yen Lum, Calvin Kam, Andrew Don, Thomas Cahill, Bernard Fong, James Lumeng, Andrew Morgan, Arch Wigle, Denis Fu, Herbert Chinn, William Iaconetti, George Mills, William Dang, Marion Hanlon, Calvin Sia, and Rodney West. Delegates from county societies included: Honolulu—Doris Jasinski, Patrick Walsh, Carl Boyer, Ann Catts, Richard Fardal, Henry Fong, Grover Batten, Charles Judd, Melvyn Kaneshiro, Thomas Kobara, Roy Kuboyama, Helen Sullivan, George Bolian, Ronald Peroff, J. I. Frederick Reppun, Nancy Edwards, Gerald Hiatt, E. Lee Simmons, Duane Beringer, Richard Tesoro, Herbert Uemura; Maui—Lawrence Allred, Gary Salenger, Donna McCleary; Hawaii—Ruben Casile, Ben Hur; Medical Student Representative—Cindy Goto.

Dr. William Dang was appointed to serve as parliamentarian for the meeting. Drs. Roy Kuboyama and Andrew Morgan were appointed sergeants at arms.

The minutes of the 123rd Annual Meeting as published in the December 1979 issue of the HAWAII MEDICAL JOURNAL were approved.

The reports of the President, Secretary, Treasurer, component societies, committees and commissions were included in the delegates handbook and referred as indicated. The resolutions were also assigned to reference committees.

Reference committees were appointed as follows: Public Health and Education—Denis Fu (Chairman), Carl Boyer, Nancy Edwards, E. Lee Simmons; Miscellaneous—James Lumeng (Chairman), Bernard Fong, Ronald Peroff, Arch Wigle; Finance and Administration—William Iaconetti (Chairman), Andrew Don, Richard Fardal, Gerald Hiatt.

The reference committees were in session October 13, beginning at 2:00 p.m.

The second session of the House of Delegates was called to order on Wednesday, October 15, 1980, at 1:30 p.m. Also present were: Drs. William Hindle, Nadine Bruce, Samuel Allison, Harry L. Arnold, Jr., O.D. Pinkerton. Delegates also present were: Honolulu—James Musgrave, Benjamin Chang, Thomas Lau, Philip Hellreich, Carl Lehamn, Walter Young; Kauai—Mark Wentworth.

AMA President Robert B. Hunter was asked to address the House of Delegates. Dr. Hunter spoke on the vital role of the AMA in representing the concerns of all physicians in the United States. Dr. Hunter also highlighted recent actions of the AMA House of Delegates.

were presented in the reference committee such as—the old principles served us well, they were stricter, the new are too loose, only minimum changes should be made to satisfy the legal problems. Dr. Seward (1979 President, Illinois State Medical Society) stated that a survey had been conducted in their state and the response was overwhelming for a change. Dr. Hotchkiss (Member, Board of Trustees) advised the reference committee that legal counsel had recommended changes which the Board of Trustees in their fiduciary capacity recommended acceptance, to bring the Principles of Medical Ethics within the requirements of the law. If the changes were not accepted, the AMA could become bankrupt (four chiropractic suits against the AMA totaling millions are now pending). This problem is in Section 3 in the new Principles of Medical Ethics. Section 5 was interpreted by the Federal Trade Commission as restricting advertising. The revised Principles of Medical Ethics was passed after a minimum of discussion on the House floor.

Joint Commission on Accreditation of Hospitals

The House directed severe criticism at the JCAH and its survey procedures. Six resolutions expressed deep dissatisfaction with JCAH requirements and the conduct of surveys. A Board of Trustees report said that the JCAH accreditation manual for hospitals tends to prescribe methods of organizing the hospital and the medical staff rather than concentrating on the quality and excellence of patient care. Nitpicking, inflexibility, inconsistent interpretation of standards, lack of empathy, and punitive attitudes were some of the complaints lodged against JCAH surveyors.

The House directed the Board to initiate a series of changes for improving the hospital accreditation process. The Board will initiate meetings with the other four corporate bodies to discuss concerns relative to JCAH, rewrite standards to eliminate ambiguities, and to increase flexibility in implementing standards, improve the quality of survey and accreditation process, reconsider the surveying of long-term facilities not affiliated with hospitals, recommend streamlining the accreditation process and extending the accreditation term from two to three or four years, and to recommend analyzing and re-evaluating the AMA's relationship with the JCAH.

Medical Education Accreditation

In a mood of conciliation and cooperation, the House authorized the Board of Trustees to eliminate dual accreditation by the LCCME and the AMA. You will recall that one year ago we voted to withdraw from the LCCME and do our own accrediting.

The House adopted a report outlining proposed changes in accrediting medical education at all levels through ongoing discussions with the parent organizations of the coordinating council on medical education and the liaison committees.

The Board's report recommended that accreditation of graduate medical education should be modified to make residency review committees responsible for actual accrediting decisions. The Liaison Committee on Graduate Medical Education functions would then change to policy development and appeals.

The Board said no changes would be needed in the accreditation of undergraduate education.

Health Maintenance Organizations

In adopting a report on Health Maintenance Organizations, the House acted to continue its policy of neutrality and fair market competition among all systems of health care delivery.

We also reaffirmed a policy against preferential subsidies and regulations to any one form of health care delivery and protested the use of federal tax money for advertising to promote Health Maintenance Organizations, so as to provide a competitive advantage to one system of health care delivery over another.

Research was encouraged into areas such as performance and cost effectiveness. The Council on Medical Services has been concerned whether cost savings may be the result, at least in part, in the enrollment of the younger population,

more reliance on non-MD professionals, underutilization of services or a tendency to receive health care outside the HMO.

National Health Insurance

The AMA policy pertaining to national health insurance was reaffirmed by the House.

The Board of Trustees was granted a degree of flexibility in dealing with Congress on this issue within the parameters of established policy. This degree of flexibility was accepted only after a brief skirmish reminiscent of past bitter, acrimonious debate over national health insurance. After Dr. Boyle (Board of Trustees) had noted that "the leadership needs flexibility to best pursue the interest of the profession," Dr. Dows of Georgia stated: "We can flex and flex in Washington, but I just hope that the flexing is not taken for lack of backbone." There was an immediate response by President-elect Hunter: "As one who has often represented AMA before Congress, I can assure you I have never been accused of lack of backbone. This House does not want shackles upon the profession and the best way to accomplish that is to avoid putting shackles on your leaders." The House concurred.

The AMA will "continue to advocate in a positive manner the superiority of a voluntary, free choice method of medical health care delivery compared to a system dominated and controlled by the federal government."

The AMA advocates the maintenance of high quality medical care within the framework of private insurance.

Physician's Role in Executions

Considerable media attention was devoted to a Judicial Council report regarding physician participation in executions. This was a timely report since four states have laws providing executions by lethal injection of a pharmacological substance.

The House adopted the report prohibiting a physician's participation in an execution. However, a physician may continue to make a determination or certification of death as currently provided by law in any situation.

The report also states that an individual's opinion on capital punishment is the personal, moral decision of the individual.

Membership

Earlier in the report I mentioned the likelihood of a dues increase proposal coming up at the 1981 Annual Meeting next June. The unprecedented rate of inflation is having a damaging effect on the Association.

Dr. James Sammons, AMA's Executive Vice President, reported that next year inflation is going to cost the AMA \$6.5 million, and the last few years alone inflation has cost the AMA at least \$12 million.

Dr. Sammons also reported that we cannot realistically anticipate any dramatically large, new sources of revenue, and that membership dues will continue to be the basic source of revenue for the Association.

Now, you and I can't do much about inflation. But we can do something in bringing in new members and keeping the members we have. The House of Delegates adopted a report encouraging state and county societies to set AMA membership goals for the coming year.

Chiropractic

A resolution by Dr. Krol, delegate from the American Society of Abdominal Surgeons, requested the AMA to "urge the National Institutes of Health or other federal agency to fund an independent and impartial study and clinical trials to evaluate the efficiency and safety of chiropractic." Dr. Krol pointed out that there were more than 20,000 chiropractors treating 8 million people annually in the United States with reimbursement authorized by Medicare, Medicaid, Workmen's Compensation and many Blue Shield and private insurance carriers. Dr. Sammons, Executive Vice President, stated: "The AMA, of course, cannot conduct such a study without bias. So let the federal government do it. If it turns out well for them, so be it. If it doesn't turn out well for them, so be it."

Obviously, with so many items of business, I can only touch briefly on a few of major interest.

AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the reference committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you can't come to the meeting, you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House.

Many, many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

Thank you for giving me this opportunity to represent our Association.

HERBERT Y. H. CHINN, M.D.
AMA Delegate

Bureau of Research and Planning

ACTION: Approved.

The Bureau of Research and Planning held two meetings this past year with primary focus on the discussion on Resolution No. 8 from the 1979 House of Delegates—to establish a Hawaii Health Corporation, a review of program planning with goals and missions for the HMA, a follow-up of Council's action for recommendation on the Cancer Commission composition, and a monitoring of possible grants and research for the Association.

Considerable discussion focused on Resolution No. 8, to establish a Hawaii Health Corporation. Many suggestions were brought forth in the development of such a corporation, and the basic problem left unresolved was that of funding. A committee chaired by Dr. Neal Winn will pursue this development to explore areas for funding of such a corporation.

Program planning with goals and missions for the HMA led into the Leadership Conference conducted in August 1980. Finalization of these goals and missions will be presented to the House of Delegates.

The HMA Council, on March 7, 1980, recommended that the Bureau of Research and Planning review the composition of the Cancer Commission with the idea that if any changes are to be made, they be submitted to the House of Delegates. This was discussed and recommendations were reported back to Council for subsequent Bylaws Committee action and recommendation to the House of Delegates.

The Bureau explored and discussed various grants and projects during the year. No active grants were pursued although the Bureau actively pursued and orchestrated the medical research aspects following the Kunia Well spillage of pesticides, meeting with the University of Hawaii, Department of Health, Environmental Protection Agency, and Kapiolani-Children's Research Board.

Recommendation:

That the Bureau of Research and Planning continue to actively pursue grants and projects as related to HMA's goals and missions.

CALVIN C. J. SIA, M.D.
Chairman

Cancer Commission

ACTION: Approved.

The Hawaii Tumor Registry was reviewed by site visitors from the National Cancer Institute in May 1980. The site visitors identified a series of serious deficiencies in data collection and analysis, and the Cancer Commission and the HMA were directed to initiate an immediate program to correct these deficiencies or lose the Registry's funding. With the assistance of the epidemiology staff of the Cancer Center of Hawaii, a comprehensive program to rectify all of the Registry operations was begun and considerable progress has been made. The Commission expects that there will be sufficient indication of the Registry's progress by the end of the

year to be removed from probationary funding of one year to regular funding for three years. The Commission is very grateful to the HMA and Registry staffs and to the epidemiology staff of the Cancer Center for providing their considerable efforts to help the Hawaii Tumor Registry through a very critical period, particularly Dr. Ward Hinds and Dr. Laurence Kolonel.

The Registry has recently completed the first phase of updating followup on its cases and reports followup since 1973 over 90%. Since followup is dependent on cooperation from all physicians, the Commission is grateful for their goodwill as well.

DRAKE W. WILL, M.D.
Chairman

Child Health Planning (Ad Hoc)

ACTION: Approved.

Because SHPDA decided at the start of the year not to incorporate any separate health plans as an appendix to the State Health Plan, no Committee meetings were held. The Child Health Plan submitted to SHPDA this past year was thus tabled by the Plan Development Committee of SHCC with portions of the Child Health Plan incorporated in various sections of the State Health Plan; i.e. neonatal and perinatal care.

Recommendations:

That this ad hoc committee be disbanded and a subcommittee for specific child health related areas be incorporated in the Community Health Care Committee of HMA.

CALVIN C. J. SIA, M.D.
Chairman

Commission on Health Service and Care

ACTION: Approved as amended.

The Commission on Health Service and Care involves the work of four committees: Community Health Care, Health Manpower, Disaster, and Health Care Costs. The reports and recommendations of these committees are printed below.

DONALD F. B. CHAR, M.D.
Commissioner

Community Health Care

The present purpose of the Committee is to be the arm of the HMA which becomes knowledgeable about political, social, and economic issues as reflected by state legislative activities and programs of SHPDA. This Committee appears to be representative of the community, both in geographical and in professional terms.

The Committee met five times in 1980 (January 21, January 28, March 12, June 20, and August 29).

At its January meetings, the Committee was presented with the need for an immediate review of the annual edition of the State Health Plan and was asked to provide official comment. This project had to be completed within a week to ten days. The Committee's official comments were submitted with the help of those who had previously been involved in this process. However, all the Committee members felt that this was a frustrating exercise and that, in subsequent years, every effort should be made to secure more time for this review.

The March meeting was devoted largely to a discussion of the legislative mechanism as it relates to HMA and an examination of the roles and expectations of the Committee. It was felt that because the health planning process is so complex, the roles and functions of the Committee and its chairman need to be developed in detail.

Most of the June meeting dealt with a request from Pat Boland of SHPDA for help in application of the Certificate of Need process as it relates to ambulatory care facilities. The Committee made a firm recommendation on this subject; the recommendation was submitted to the HMA Council and resulted in official action.

At the August meeting, discussion led to further definition of the function of the Committee and its role in the HMA. The Committee's recommendations for its future

functioning in the HMA are submitted at the end of this report.

Chairman's Recommendations:

I came to my role as Chairman of the Community Health Care Committee this year in great ignorance of the scope and depth required for effective work in this Committee. After working with the Committee for the past nine months, I am left the following impressions. There are critical problems facing the Committee as it is presently constituted. Some of these are:

1. Most of the Committee members lack the depth and breadth of political knowledge needed to evaluate the programs they are asked to evaluate. A plan to develop a cadre of well-grounded physicians with in-depth knowledge of these matters who are willing to devote time to the work of the Committee is needed. These physicians should be carefully chosen to represent all geographic and professional segments of the medical community.

Continuity is necessary for effective Committee action from year to year. One way of establishing continuity is to have 3-year staggered terms for members. The Chairman, a carefully selected individual who is interested in the job and understands it, would serve a 3-year term, to support the need for continuity. Planning for member and chairman turnover on the Committee is important (to avoid a sense of being "stuck" with the job). This can be done by continually seeking out physicians interested in the Committee's work and orienting them to Committee activities.

If the Committee is to function effectively, it will require strong staff assistance. By the very nature of the political process and its great impact on all of us, it seems that increasing paid staff support will be required for this function of the HMA. The present staff, both Becky Kendro and Jon Won, have supported my actions as Chairman efficiently and effectively. However, our approach has been stopgap at best during this year. If the HMA is to have knowledge and input about developing programs, it will need a far greater commitment to the political process, and this will require paid staff; that the HMA reassess its priority so that sufficient staff is made available to carry out the recommendations of the Committee.

2. A serious problem is the wealth of political problems that face organized medicine as they emanate from state, national, and local regulatory bodies. I suggest that we in HMA, both staff and physicians, need a thorough efficient means to develop and maintain awareness and analysis of these political developments.
3. The last-minute notification about major programs, such as the State Health Plan and Appropriateness Review, is a severe handicap that we must make every effort to alter. It is suggested that official communication between the HMA and SHPDA be instituted in an effort to allow the physicians of HMA to have more lead time to consider important developments.

Suggested Future Directions:

I believe the Committee should have an agreed-upon, solid mission. My vision of the tasks of the Committee in the future would include:

1. To review and analyze health planning developed by SHPDA and the state and national governments;
2. To seek and obtain adequate physician representation on decision-making bodies, including the legislature and SHPDA and any other regulatory agencies. This representation should be at a level where basic decisions are made, such as the subjects of SHPDA review, choices of reviewers, etc.;
3. To develop a pool of physicians knowledgeable in health planning who agree to participate in planning meetings and selected public hearings;
4. To initiate an educational program for physicians concerning the legislative and regulatory processes and their immediate implications.

5. To request the HMA Legislative Committee to seek repeal of that portion of the Certificate of Need Law that applies to the private practice of medicine.
6. To increase staff such that health planning activities can be monitored on a day to day basis.

ROBERT L. KISTNER, M.D.
Chairman

Disaster

The HMA Disaster Committee did not meet formally all year but the Chairman and several committee members of the HMA Disaster Committee did meet with members of the Honolulu County Medical Society Disaster Committee to attend a briefing given by the Director of the City's Emergency Operating Center.

Recommendations:

That the Committee continue to exist and to meet on an on-call basis.

LEONARD HOWARD, M.D.
Chairman

Health Care Costs

The Health Care Costs Committee met with representatives of HMSA and with hospital administrators and chiefs of staffs in an effort to explore ways of reducing the rate of increase in health care costs. Of primary concern during the past year has been the costs of ancillary services in the hospitals and ways to encourage physicians to increase the scope of office surgery. It is hoped that dialogue between HMSA and the members of the Hospital Association has been stimulated by discussion within the Health Care Costs Committee.

Developing awareness among practicing physicians of their role in containing health care costs involves a slow process of education. Consequently, even though little progress can be demonstrated at this time, it is recommended that the efforts of this Committee be continued.

MARION L. HANLON, M.D.
Chairman

Health Manpower

The basic objectives as outlined last year have continued to guide this Committee in monthly meetings. Major developments include the following:

1. Substantial HMA input in development of the chapter on Physician Manpower in the most recent update of the State Health Plan (SHPDA).
2. Major HMA support of the Hawaii Cooperative Health Statistics System, which published its detailed manpower report entitled *Health Occupations Profile of Hawaii Physicians Engaged in Patient Care: Preliminary Report*. This will now serve as our data-base.
3. Meeting with University of Hawaii School of Medicine authorities to initiate dialogue concerning future planning for the School of Medicine and its impact on the local manpower situation.
4. On-going meetings with Hawaii Nurses Association, University of Hawaii School of Nursing leadership, and nursing practitioners in the community. In addition to addressing manpower issues of mutual concerns, this collaborative group has also reviewed proposed changes in the Nursing Practice Act.
5. Meeting with representatives of the Hawaii Academy of Physicians' Assistants to better assess the role, function, and potential manpower impact of this particular group of allied health professionals. As a result, multiple specific recommendations for certification and standards of practice have been developed for submission to the State Board of Medical Examiners.

GEORGE C. BOLIAN, M.D.
Chairman

Commission on Medical Education

ACTION: Approved as amended.

Purpose:

The purpose of the Committee on Continuing Medical Education is:

- 1) to accredit hospitals, specialty societies, and medical organizations, for continuing medical education according to the guidelines of the American Medical Association;
- 2) to establish standards for continuing medical education and encourage the development of high quality programs pertinent to the needs of local physicians;
- 3) to coordinate and publicize continuing medical education activities within the State of Hawaii;
- 4) to help physicians fulfill their CME requirements.

Activities:

The Continuing Medical Education Committee met monthly during the past year and accomplished the following tasks:

- 1) The Committee sent a survey team to the Honolulu Medical Group Research and Education Foundation for their first time accreditation visit. The Committee recommended a two-year provisional accreditation for the Foundation.
- 2) The Committee sent survey teams to the following hospitals, specialty societies, and organizations for continuing medical education resurveys: G. N. Wilcox Memorial Hospital; Kaiser Foundation Hospital; Kuakini Medical Center; Wahiawa General Hospital; Children's Medical Center; Kapiolani Medical Center; St. Francis Hospital; Straub Clinic & Hospital, Inc.; Queen's Medical Center; American Cancer Society, Hawaii Division; Hawaii Psychiatric Society; and the Maui Federation for Emergency Medicine. The Committee recommended a four-year full accreditation with progress report in two years for each of these institutions.
- 3) The Committee accredited the following programs for Category I with the Hawaii Medical Association as co-sponsor:
 - a) "Symposium on Cisplatinum," sponsored by the Community Cancer Program of Hawaii; 4 hours of Category I.
 - b) "Selected Problems in Laboratory Medicine," sponsored by Kwajalein Missile Range Medical Staff; 7½ hours of Category I.
 - c) "Communications Disorders Workshop," sponsored by the Hawaii Speech and Hearing Association; 12½ hours of Category I.
 - d) "Facial and Nasal Trauma," sponsored by the Maui County Medical Society; 2 hours of Category I.
 - e) "Human Nutrition," sponsored by Lederle Laboratories; 6 hours of Category I.
 - f) "PacPSRO Physicians Advisory Seminar," sponsored by PacPSRO; 2 hours of Category I.
 - g) "Medicine in the 80's—State of the Art," sponsored by the Unity Church of Hawaii; 7 hours of Category I.
 - h) "Services of the Blood Bank of Hawaii," sponsored by the Honolulu County Medical Society; 1 hour of Category I.
 - i) "Intraocular Lenses and Radial Keratotomy, an Update," sponsored by the Hawaii Ophthalmological Society, 1 hour of Category I.
- 4) The Committee accredited the following programs for Category I with the Hawaii Medical Association as sponsor:
 - a) "Maternal and Perinatal Mortality Study Committee"; monthly evening meetings were accredited on an hour-for-hour basis for a period of one year.
 - b) "HMA Annual Meeting"; Category I was granted on an hour-for-hour basis for this year's annual meeting.
- 5) The Committee maintained HMA/CME record-keeping system and correlated the sending of 1979 records without charge to HMA members in the spring of this year.
- 6) The Committee helped the HMA staff coordinate the transition of our record-keeping system to a computer

system. As of January 1980, all records of Category I programs accredited by the HMA, or by organizations accredited by the HMA, will be kept on computer.

- 7) The Committee has continued to review and keep up to date the calendar of CME events in the Hawaii Medical Journal.
- 8) The Committee is currently working with Dr. Paul Tamura, and the Kwajalein Missile Base Medical Staff, to develop an on-going program of continuing medical education for the physicians on Kwajalein.
- 9) The Committee has maintained liaison with the University of Hawaii School of Medicine, also an accredited institution for Category I, to better correlate local CME and make available to physicians a wide range of CME activities.
- 10) At this year's annual meeting, we will be surveyed by the American Medical Association for continued accreditation of continuing medical education. It is anticipated that we will receive accreditation without any problem.

Recommendations:

- 1) That the HMA continue in its present role as an accrediting body for the intrastate providers of continuing medical education.
- 2) That the HMA continue to provide yearly print-outs of CME records free of charge to its members.
- 3) That the HMA not release print-outs of CME records to non-members.
- 4) That HMA and institutions accredited by HMA maintain records of attendance only for physicians (MDs and DOs) and that certificates only be issued to same.
- 5) That the HMA charge for co-sponsorship of Category I courses using the following guidelines: a program without tuition charges will not be charged a co-sponsorship fee; a program with up to 10 hours of Category I credits will be charged a \$25 base line fee; a program with over 10 hours of Category I credits will be charged a \$50 base line fee; for special services the HMA may charge up to \$150, the exact fee to be determined by the Committee on a program by program basis.
- 6) That the HMA re-evaluate, in the next year, the requirement for mandatory CME for membership, for report back to the House of Delegates in 1981.
- 7) That the HMA continue to support mandatory CME as a requirement for relicensure until viable alternate methods for assuring quality medical care can be implemented.

NADINE C. BRUCE, M.D.
Chairman and Commissioner

Commission on Medical Services

ACTION: Approved as amended.

The Commission on Medical Services consists of three committees: (1) Fee Survey, (2) Worker's Compensation, and (3) Economic Evaluation and Adjustment. The reports of these committees are as follows:

WILLIAM W. L. DANG, M.D.
Commissioner

Fee Survey

The Fee Survey Committee during the past year has met on numerous occasions to try to resolve the problem of how to publish an up-to-date relative value studies. The Committee has oscillated between publishing a procedure code with no relativities or publishing nothing and continuing with the use of the old RVS.

It is basically the feeling of some of the members including the chairman that the medical society should publish a completely new RVS with relativities. We feel that the case won by the American Anesthesiology Association gives legal precedent to publish an RVS. Publication of a procedure code without relativities would probably in the long run not be beneficial to the membership of HMA.

MAURICE W. NICHOLSON, M.D.
Chairman

Worker's Compensation

The Worker's Compensation Committee was active this year at the Legislature in attempting to repeal the requirement for publishing an annual Medical Fee Schedule and substitute a system which would utilize a Relative Value Studies and fixed conversion factors which would be determined by the State. The bill to accomplish this went to last reading with the support of the Department of Labor, insurance industry, and the Medical Association. It failed to pass due to the Legislature's wish that the entire system of Worker's Compensation be re-evaluated as to compensation. A Worker's Compensation Commission was created by the Legislature for the sole purpose of re-evaluating the entire system of Worker's Compensation. The Commission includes representatives from labor, business, and government but does not include a representative from the medical profession. In correspondence with the Governor, the HMA has been assured of participation in the Commission's review of the law. Another bill which would have allowed the usual, customary and reasonable concept for reimbursement also failed.

Testimony was given at public hearings before the Department of Labor in August in attempt to get new additions made to the State's Worker's Compensation Fee Schedule which would include new diagnostic and surgical procedures as well as expanded codes for office visits. The result of this testimony is yet to be determined.

ROBERT CLINGAN, M.D.
Chairman

Economic Evaluation and Adjustment

This committee is charged with the responsibility of negotiating fee schedules with various organizations in the community. The committee had no occasion to meet in 1980.

DOUGLAS B. BELL, II, M.D.
Chairman

Commission on Public Health

ACTION: Approved as amended.

The Commission on Public Health consists of the following committees: Cancer, Chronic Illness, Communicable Disease, Crippled Children, Public Safety, School Health, Sports Medicine, and Substance Abuse/Pharmacy. The reports of the committees and recommendations follow.

THOMAS G. CAHILL, M.D.
Commissioner

Cancer

The HMA Cancer Committee has met on four separate occasions focusing on guidelines for cancer management, health screening, on-going and joint programs with the CCPH, relationships with NHI, and discussions regarding plans for a proposed melanoma clinic.

The Cancer Committee of the HMA and the HMA Council have recently decided to enter into a formal agreement with the Community Cancer Program of Hawaii to construct, distribute and update outlines for cancer management. Health screening notes were also accepted by the HMA Council to develop written policy regarding health screening procedures to benefit those programs asking for HMA's endorsement or support.

Recommendations:

That the HMA Cancer Committee continue to function as at present.

JOHN P. KEENAN, M.D.
Chairman

Chronic Illness

The main consideration of the Chronic Illness Committee in 1980 has been an evaluation of proposed legislation relating to long term care. A bill on this subject was introduced in the House of Representatives by Byron Baker and testimony presented by HMA. The bill was referred to committee for revision, and Representative Baker invited comment from interested parties.

The Chronic Illness Committee invited two non-physician representatives in the field of long term care to its own discussion of the bill. Major concerns were the vesting of all control in the Department of Social Services and Housing, and the diminished importance given to physicians in the care of their patients. The latest draft revision still places major responsibility with DSSH and will still render the bill unacceptable to many agencies, including HMA, if not changed before presentation to the 1981 Legislature. The Committee anticipates a further meeting in 1980. Copies of the Bill Relating to Care are on file at HMA for interested parties.

The Committee conducted a survey on physician's interest in seeing geriatric patients and in receiving referrals of such patients. The results demonstrated that a high proportion of physicians do express an interest in elderly patients and would welcome them to their practices. Results of the survey have been passed on to the HMA Staff for referral purposes.

GLADYS C. FRYER, M.D.
Chairman

Communicable Disease

The HMA Communicable Disease Committee has met on two separate occasions. The first meeting was a joint meeting with the HMA School Health Committee (May 22, 1980) and at that time it was recommended that: (1) HMA accept the old SHS 20 Form which states that history of disease is not acceptable for rubella but is acceptable for mumps and measles, and (2) HMA ask the DOH to place head lice on the excludable disease list once again.

The second meeting was held on August 22, 1980, and these three recommendations were made: (1) that proposed changes to Chapter 23 (Public Health Regulations Relating to Tuberculosis) made by the Tuberculosis Branch of the Department of Health be accepted, (2) that the draft letter to all physicians from the DOH notifying changes at Lanakila Health Center regarding tuberculosis be accepted in principle and be disseminated to all physicians in Hawaii by the Department of Health, and (3) that the Communicable Disease Committee recommends that HMA work with the Tuberculosis Branch of the Department of Health at Lanakila Health Center to provide free TB treatment for private physicians.

Recommendations:

- 1) That the Communicable Disease Committee will continue to meet with the Tuberculosis Branch of the Department of Health, the Epidemiology Branch, etc., in terms of approving the immunization programs, the school health programs, etc; and
- 2) That the Communicable Disease Committee continue to meet with appropriate physicians and community persons regarding any anticipated outbreaks.

FRANCIS PIEN, M.D.
Chairman

Crippled Children

The Crippled Children Committee met once during the year to discuss the State Crippled Children's Revised Plan and made appropriate suggestions. This will be followed-up in the forthcoming year.

D. V. REDDY, M.D.,
Chairman

Public Safety

The Public Safety Committee had one meeting during the year in which it was decided to actively support the motorcycle safety helmet law. The bill was before the Legislature, but never came to the Committee.

Recommendations:

That active support be given the motorcycle safety helmet bill when it comes before the Legislature.

TRUETT V. BENNETT, M.D.,
Chairman

School Health

The School Health Committee was not able to implement the 1979 School Health Manual with guidelines for participation in contact sports as no definitive recommendations were available from the American Academy of Pediatrics for perusal with AMA recommendations. However, the School Health Committee was instrumental in having the SHS-20 physical examination form modified from history of disease *not* acceptable for measles, mumps, and rubella to history of disease *not* acceptable for rubella only.

Dr. Frances Riggs is the new Chief of the School Health Services Branch replacing Dr. Jeremy Lam who has gone into private practice.

A current problem facing the School Health Committee concerns who will be permitted to dispense medicine in the school situation including Kwell shampoo for head lice and other physician prescribed medication.

ANN BARBARA HO YEE, M.D.,
Chairman

Sports Medicine

The Sports Medicine Committee met regularly throughout the year at monthly intervals. The following goals were allotted to this Committee:

GOAL #1: Plan and implement a Sports Medicine Seminar for coaches and trainers.

Sports Medicine Committee held a seminar for the coaches and other people on August 9 at McKinley High School. It was a whole day seminar attended by approximately 70 people.

Dr. Russell Hicks was the coordinator of the seminar and did an excellent job in finding speakers for the program. The afternoon workshops for taping and padding were very well attended and appreciated by the coaches and the trainers for the various places: Punalou, Kamehameha, University of Hawaii, and Iolani and did a tremendous job.

GOAL #2: Meet with representatives of the University of Hawaii and the *Honolulu Advertiser* to review their methodology of reporting injured athletes in an attempt to utilize one system.

The Committee met with Dr. Ralph Hale, who reported the findings of his study in some detail during the seminar. He is going to continue the same study with some modifications.

GOAL #3: Include neighbor islands in the seminar by sending a committee representative to neighbor islands to confer with coaches, athletic officials, etc.

The Committee wrote letters to the outer islands promising them to help with the speaker for similar seminars as they will arrange it, but there was no response from any of the islands.

GOAL #4: That sports medicine activities keep within the budget amount for the Committee (\$500).

Sports Medicine Committee kept within the budget and spent only \$150.

Recommendations:

The Committee recommend that there be two seminars held next year, one in January addressing the specific needs for spring sports like track, field, soccer, etc., and the second seminar planned for August to address specific needs of football and similar sports. These seminars should be for one day each, the afternoon being allotted to the workshops.

The Committee also felt that the publicity for these seminars could be improved considerably by contacting schools prior to summer vacations.

Further, the Committee recommends that consideration be given to increase its budget so they can plan to have more similar seminars on the outer islands.

The problem about communication between the doctors and coaches should be conducted to be looked into for improvement.

B. R. MEHTA, M.D.,
Chairman

Substance Abuse/Pharmacy

The Committee met six times last year and sent members and representatives to testify and to communicate the concerns of physicians regarding proposed legislation on generic drugs (passed), patient's right, use of marijuana for medical research and the use of heroin for pain control. When the DSSH Drug Formulary came out, the Committee reviewed in detail the regulation and reacted promptly by soliciting input from various specialty societies and concerned physicians. These objections to the Formulary were forwarded in writing to DSSH and its pharmacist consultant. In addition, the Committee also met with representatives of DSSH and presented our grave concerns.

Actions taken at various times throughout the year include the following:

1. To alert all physicians through the HMA Journal on the possible dangers of prescribing certain drugs to individuals who abuse alcohol;
2. To assist the Substance Abuse Branch of DOH in developing accreditation standards for substance abuse and alcohol treatment facilities that are receiving state and federal funds; and
3. To support the work of DASH (Drug Addiction Service of Hawaii) through HMA legislative effort in requesting the State to provide adequate financial aid.

It is recommended that the Substance Abuse and Pharmacy Committee continue its current activities for the coming year.

JAMES LUMENG, M.D.,
Chairman

Convention Chairman

ACTION: Approved.

This year's scientific program was developed through cooperation with the University of Hawaii School of Medicine's Postgraduate Education Committee under the direction of Ralph Hale, M.D. After several planning sessions, the appropriate postgraduate courses were selected and faculty members chosen. It is our hope that future efforts in continuing physician education be closely coordinated with those of the University of Hawaii.

Recommendation:

That HMA continue coordination with the AMA to provide a regional meeting in conjunction with our state annual meeting.

HERBERT UEMURA, M.D.,
Chairman

Jail Health

ACTION: Approved.

The Hawaii Medical Association was awarded a subcontract from the American Medical Association in November 1979 to improve medical care and health services in jails through adoption of AMA Jail Health Standards. Hawaii is one of 23 states participating in the Jail Health Program with the AMA who received funding from the Law Enforcement Assistance Administration. The subcontract will extend through May 31, 1981.

The Hawaii Medical Association's Jail Health Committee is charged with the responsibility of providing technical assistance to all jails that have been accepted as participants in the program, to provide sample forms, policies and procedure documents and other support materials, to make on-site visits to work with the jail staff, to assist jails to locate needed medical and other resources, to conduct training sessions for corrections officers, and to make periodic reviews for defining action plans.

In the first six months, the Committee made on-site visits to the correctional centers of Maui, Kauai, Hawaii, Oahu, and the Halawa High Security Facility. The health care system in each facility was reviewed and compared to AMA standards. Standards not being met have been identified and reported to the Corrections Division of the DSSH. A state action plan for providing technical assistance to DSSH has also been de-

veloped. The Committee has also served in an advisory capacity to the Corrections Division. Our immediate goal is to develop a proposed policy manual and to work with individual facilities on the implementation of such policies including the quest for legislative appropriation.

The members of the Jail Health Committee included Dr. Nadine Bruce, Dr. Albert Chun-Hoon, Dr. James Lumeng, and Dr. Neal Winn. The state project coordinators are Becky Kendro and Jon Won. The Committee has no recommendations other than to continue the work in 1981.

WALTER W. Y. CHANG, M.D.
Chairman

Proposed Statewide Medical Examiner System (Ad Hoc)

ACTION: Approved.

In November 1979, the pathologists in the State of Hawaii were informed that the acting medical examiner for the City and County of Honolulu will be retiring in the near future and inquiries were made for a qualified pathologist interested in an appointment as the medical examiner for the City and County of Honolulu. On the basis of this information, an ad hoc committee was formed with representatives from the Hawaii Society of Pathologists, the Department of Pathology of the John A. Burns School of Medicine, the Hawaii Bar Association, and the Hawaii Chapter of the American College of Obstetricians and Gynecologists to work for a statewide medical examiner system. The bill which was previously introduced in the Fifth State Legislature was updated and introduced in the House of Representatives and the Senate. The bills did not pass because of opposition from the City and County of Honolulu and because the financial impact of the proposed statewide system was not clearly delineated.

In order to resolve the problem involved, identical resolutions were introduced in the House of Representatives and the Senate requesting the Legislative Reference Bureau to conduct a feasibility study and prepare a plan for the uniform State Medical Examiner System. Both resolutions were referred to the respective Legislative Management Committees of the House and the Senate where the fate of the resolutions is at the pleasure of the chairman of the respective committee.

Recommendations:

- 1) That the Ad Hoc Committee on the Proposed Statewide Medical Examiner System continue in its efforts until a statewide system is enacted.
- 2) That the newly appointed medical examiner for the City and County of Honolulu and other interested persons be invited to become members of this Committee and long term strategies be developed and carried out.

GEORGE GOTO, M.D., *Chairman*

Resolution No. 2

ACTION: Not Adopted, but with the recommendation that the concept be re-evaluated in the interim for report back at the 1981 Annual Meeting of the House of Delegates.

Re: Requirement for Mandatory CME for Membership in the HMA

WHEREAS, the concept of continuing medical education has always been a part of the medical profession's philosophy, and

WHEREAS, the American Medical Association has never supported the concept of mandatory continuing medical education as a requirement for membership, and

WHEREAS, the Hawaii Medical Association has always supported and encouraged voluntary continuing medical education, and

WHEREAS, the necessity for mandatory continuing medical education is a redundant requirement that fails to serve the purposes for which it was enacted, therefore, be it

Resolved, that the Hawaii Medical Association rescind the requirement of mandatory continuing medical education for membership in the Hawaii Medical Association.

NADINE C. BRUCE, M.D.

Resolution No. 4

ACTION: Adopted as amended.

Re: Physician's Assistants

WHEREAS, the first Health Manpower Committee of Hawaii Medical Association was formed in 1970, and

WHEREAS, one of the first tasks of the committee was to define the term "physician's assistant" as being an individual "who is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps; assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other more technical assistants; and functions under the general supervision and responsibility of the physician although he might under special circumstances and under defined rules perform without the immediate surveillance of the physician; and is thus distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment,"* and

WHEREAS, the 1973 HMA House of Delegates supported a delegatory type amendment to the Medical Practice Act to allow delegation by physicians to physician's assistants, and

WHEREAS, the Hawaii Medical Association has been asked by the Board of Medical Examiners, the Hawaii Academy of Physician's Assistants, and the Hawaii State Legislature to define its position relative to physician's assistants, now therefore be it

Resolved, that the HMA House of Delegates reaffirm its support of the present statutes governing physician's assistants in the Medical Practice Act; and be it further

Resolved, that authority for PA practice should be delegatory; i.e. by formal delegation of medical authority of the sponsoring physician;

That PAs need not be licensed, but they should be formally certified by the State with criteria for certification which includes minimally (1) successful completion of the full course of training in a program accredited by the AMA Committee on Allied Health Education and Accreditation or its equivalent, and (2) current *active* certification by the National Commission on Certification of Physician's Assistants;

That active practice on the part of a certified PA in Hawaii should be authorized only on the application of a licensed physician who indicates his willingness to accept responsibility for the specific PA; in general, a single physician not be allowed to sponsor more than two PA's at any one time; and to specify to the Board the scope and locality of PAC activities.

That the sponsoring physician should provide on-the-premises supervision as the rule, although the Board should allow specific exceptional circumstances such as rural areas and great distances;

That the PA, as a rule, should not be permitted to prescribe drugs, although again there should be specific allowance for exceptional circumstances;

That any role of the PA under the sponsorship of a practicing physician should be delineated by every hospital in accordance with individual circumstances.

That PA's should be allowed to participate in hospital practice so long as it is under the sponsorship of a practicing physician with privileges in the given hospital;

That PA's should not be employed directly by hospitals or other health facilities; and

That reimbursement by third party payors should not be directly to the PA, but to the sponsoring physician.

GEORGE BOLIAN, M.D.
for the HMA Health Manpower Committee

*Type A Physician's Assistant defined by the National Academy of Sciences

Resolution No. 6

ACTION: Not Adopted, but referred to the HMA Council for further study. (Note: Subsequent action taken by HMA Council, November 7, 1980)

Re: Eye Safety

WHEREAS, recent nationwide studies of cases of unnecessary severe eye damage reveals that one of the most frequent causes of said damage is the failure of non-medical practitioners to suspect eye disease and properly advise the patient of the need for evaluation or treatment by a medical doctor; and

WHEREAS, such cases have resulted in needless blindness and suffering throughout the nation, including Hawaii; and

WHEREAS, the individual patient has the right to know when signs observed by non-medical practitioners or symptoms reported to him indicate the need for consultation with, or treatment by, a medical doctor; and

WHEREAS, there is ample precedent for government requiring health safety standards be met and warnings be issued regarding products or services which may jeopardize the public health; and

WHEREAS, eye examinations are being provided to the patients of medical doctors in Hawaii by non-medical practitioners who may fail to refer possible evidence of eye disease to medical doctors; and

WHEREAS, medical ethics demand that Doctors of Medicine provide their expertise and advice to government on issues affecting the public health; and

WHEREAS, the organization recognizes the precious gift of eyesight as the most valuable of the sense;

Resolved, that the members of the Hawaii Medical Association urge all State Legislators to pass a law requiring that each patient having an eye examination by a non-medical practitioner be advised to seek medical evaluation or treatment by a medical doctor when certain signs or symptoms are reported by the patient or observed by the examiner. To facilitate and document this referral, a Medical Eye Safety Checklist form shall be completed for each patient examined.

JOHN M. CORBOY, M.D.

Resolution No. 7

ACTION: Adopted.

Re: Emergency Medical Services

WHEREAS, 18 million children receive emergency medical services annually in this nation,

WHEREAS, 20 to 35% of all patients receiving care in hospital emergency rooms are children and youth,

WHEREAS, one of the leading causes of death in early infancy and childhood is accidents and poisonings,

WHEREAS, 100,000 children are permanently crippled by trauma annually,

WHEREAS, 55% of all deaths up to age 15 are due to injuries,

WHEREAS, Child abuse and neglect with Failure to Thrive must be considered in early detection and prevention, therefore be it

Resolved, that the Hawaii Medical Association strongly support current legislation to establish Prevention and Emergency Child Health Care System under existing Emergency Medical Service Division, Health and Human Service Department, and be it further

Resolved, that the Hawaii Medical Association support the study of establishing local pediatric standards of care in emergency services in concert with the Hawaii Chapter American Academy of Pediatrics currently underway.

CALVIN C. J. SIA, M.D.

Reference Committee on
Miscellaneous Business

Commission on Interprofessional and
Public Affairs

ACTION: Filed

The Commission on Interprofessional and Public Affairs consists of three committees: Public Affairs which includes the Tel-Med functions, Television-Radio, and Publications. The reports of these committees are listed below:

PHILIP I. MCNAMEE, M.D.,
Commissioner

Public Affairs

ACTION: Approved as amended, with the recommendation that the award to a physician for accomplishment in medical journalism be made to a member of HMA.

The committee met monthly and occasionally more often. A number of projects were undertaken and completed. The committee:

- 1) Recommended that the Council establish an award to physicians for their accomplishment in medical journalism.
- 2) Provided physicians as judges for the Hawaiian Science and Engineering Fair.
- 3) Clarified the HMA position on specialty listing in the telephone directory.
- 4) Developed a plan for a special issue of the HAWAII MEDICAL JOURNAL to commemorate the 125th anniversary of the HMA. Also, plans were organized for a special commemorative newspaper supplement to incorporate some of the Journal articles.
- 5) Selected the HMA Physician of the Year (Robins Award).
- 6) Selected a local apparel company to design material as a special commemorative for the 125th anniversary of the HMA.
- 7) Developed the idea for a special pageant, involving HMA members, to commemorate the 125th anniversary of the HMA.
- 8) Selected winners for the HMA Medical Journalism Award.

Budget Request:

Public Affairs	
125th Anniversary Project	\$1,000
News Media Award	800
Science Fair	200
Tel-Med	8,000
Dues & Subscriptions	-0-
Postage	-0-
Stationery, Printing	-0-
Medical Student Affairs	-0-
	<hr/>
	\$10,000
TV-Radio	
Video Cassette & Prod. Costs	5,200
	<hr/>
	\$15,200

GERALD A. HIATT, M.D.,
Chairman

Publications

ACTION: Approved with the exception of recommendation no. 3, and with the recommendation that a new roster be printed in 1982 using the same format as previous rosters.

The Publications Committee met three times during 1980, in January, March, and May, dealing mainly with the HMA Journal.

Main topics considered during the year were:

- 1) *Financial Considerations:*
Evaluation of financial status of the HMA Journal and how to make the journal self-supporting were discussed at

length. For several previous years the journal has had advertising receipts in excess of expenses, and for other years the expenses have exceeded receipts. The ideal would be to have receipts and expenses equal each other annually, since the journal may not make a profit, according to post office regulations.

A national advertising representative was sought, in an effort to increase national ads, mainly from pharmaceutical firms. A contract was executed with United Media Associates, to commence June 1, 1980.

Means to increase local advertising will also be pursued, to improve this source of support.

Regarding subscription rates, this has remained stable at \$10.00 for several years. Whether this is to be increased or waived for members is a matter that should be discussed by the Finance Committee or House of Delegates.

2) Editorial Matters:

Internal means of saving on publication expenses have been discussed particularly with respect to the size of each issue and type sizes. Space might be saved by employing smaller typeface throughout.

The question of whether a quarterly or bi-monthly journal would be more economical than a monthly has been evaluated in previous years, and it was found that monthly publication is better, especially from an advertising viewpoint.

The articles published continue to be primarily of a Hawaiian nature. (The matter of giving up the HAWAII MEDICAL JOURNAL as an independent journal, to become part of the Western Journal of Medicine, for example, keeps coming up. The Western Journal of Medicine serves several western states of the continental U.S. Since Hawaii is a "Pacific" state and not a "Western" state, how Hawaii medicine would be served by joining a western U.S. journal is difficult to see. Hawaii's articles could not have much meaning for western readers nor would Hawaii-originated articles be expected to garner much of a place in competition with articles from California and other western states, in a journal which is edited and published on the mainland.)

3) Special HMA Anniversary Issue:

A meeting was held with Public Affairs Committee members to plan a special issue in mid-1981 for the 125th anniversary of the HMA.

4) HMA Roster:

This was not specifically discussed. A suggestion has been made that HMA publish a roster of all physicians practicing in Hawaii, and charge non-members for their listing. This would present a more complete list of the physicians in Hawaii, including particulars as to medical schools, etc.

5) Miscellaneous:

In March, Mr. Albert Yuen of the HMSA met with the committee, including Dr. Arnold, editor of the HAWAII MEDICAL JOURNAL. Mr. Yuen expressed his distress at the tone of Dr. Henry Yokoyama's News and Notes reportage of an HCMS meeting at which HMSA representatives spoke. Although Mr. Yuen's injured feelings seemed somewhat excessive, with respect to Dr. Yokoyama's reporting, his meeting with our committee seemed to salve his concern somewhat.

Recommendations:

- 1) That the HAWAII MEDICAL JOURNAL continue monthly publication as an independent Hawaiian-Pacific journal.
- 2) That Dr. Harry Arnold, Jr. continue as editor.
- 3) That a new roster be printed in 1981 and that consideration be given to compiling a roster of all practicing physicians in the state, charging non-members for their listing.

TV-Radio

ACTION: Filed with recognition of the TV-Radio Committee for its accomplishments and excellent programs.

The purpose of the TV-Radio Committee is to institute and coordinate appropriate medical presentations in these

electronic media, in order to educate the public in medical matters and in the role of physicians in maintaining the health of the community.

During the past year, the chief business of the committee was:

- 1) supervision of production of a 26-part television series, *Your Body, Your Mind*, which appeared weekly on KHET (Channel 14) and on all the cable stations. The series was jointly sponsored by the HMA and Tel-Med (HMSA), produced by Paul Berry Associates, filmed at Punahou School, and featured conversational interviews with HMA physicians and health educators.
- 2) promotion of this year's series, which included a newspaper campaign, fundraising, a poster and flyers, etc. All evidence indicates a vastly increased audience.
- 3) planning for the 1980-81 season which will feature *Your Body, Your Mind* as a 26-part weekly video series, sponsored by HMA and HMSA, to follow a format similar to last year's successful program. This series will be more heavily promoted than in the past, and two additional physician hosts, Dr. Malcolm Ing and Dr. Georges Hufnagel, will participate.
- 4) long-range planning for production and sponsorship of a new kind of television program for the 1981-82 season, to be filmed and broadcast by a commercial television station.
- 5) assistance and guidance to public affairs programs of a medical nature, as aired on K-108.
- 6) providing speakers for radio talk-shows and for medical public service commercials.

Next Year's Program

During the coming year, the committee will continue with its present television and radio commitments, and assist in other activities as requested.

In future programming, emphasis will be placed on the individual's role and responsibility in maintaining his or her own health, on preventive measures, and on economics of medical care.

The budget for the continuation of the TV-Radio Committee is included in the Public Affairs budget request. We are grateful for the funds and cooperation provided by HMSA through Tel-Med, who supported production of new shows and developed an intensive promotional mail campaign for our TV series.

JOHN CORBOY, M.D.
Chairman

Tel-Med

ACTION: Filed with a vote of commendation on the continued success of the Tel-Med program.

The Tel-Med Program is a collection of tape recorded health messages available free of charge to the public by telephone, and is jointly sponsored by the HMA and HMSA. The committee's purpose is to maintain liaison with HMSA in this joint public education effort. Tel-Med continues to receive numerous calls from the public. The Committee had no occasion to meet this year.

GERALD A. HIATT, M.D., and
ROWLAND LICHTER, M.D.,
Representatives

Commission on Legislation

ACTION: Approved as amended, with the recommendation that the tentative listing of 10 bills which HMA might consider introducing in 1981 be referred to the appropriate committees of HMA for immediate action prior to the beginning of the 1981 legislative session.

The Committee recommended to the HMA Council that Mr. Jonathan Won, our Executive Director, serve as the lobbyist for the Association and that Judge Kazuhisa Abe serve on a piece-work-as-needed basis to do legal counseling, to assist in writing bills and to assist in opening doors to certain legislators during the 1980 session of the Tenth State Legis-

lature. The Council approved these recommendations. Jon Won took to lobbying as a duck takes to water and effectively advocated our cause in the halls of the Legislature.

The almost impossible task of monitoring the health and medically related bills and resolutions has been superbly handled by Mrs. Becky Kendro, our Supervisor of Governmental Affairs and Research. She has developed an expertise in this area which is highly commendable.

Because of the increasing volume of bills and resolutions relating to health and medicine, the responsibility for initiating and responding to the legislative proposals have been given to the various committee chairpersons, specialty society presidents, and individuals who have expertise in the particular subject matters. The ready acceptance of these responsibilities by the individuals mentioned above has been very gratifying. These individuals have called meetings of the committees they chair or have formed ad hoc committees to discuss the measures referred to them. The testimonies were then written with the assistance of the staff and presented at hearings. In particularly controversial measures, intense lobbying activities were carried out prior to hearings so that commitments from key legislators could be obtained early in the course of the legislative process to favor our stand.

The status reports of the legislative measures were sent periodically to the members of the Association in the form of *The Legislative Roundup*. The HMA Council was kept informed of the activities in the Legislature during each meeting of the Council. Among the major issues confronted were:

Measures	Description	HMA Position	Status
State Budget	Increased Medicaid Profiles for MDs	Support	Passed
SB 1827	Rules of Evidence for physician-patient privilege	Support	Passed
SB 2134	Generic Drug Substitution Law	Support	Passed
SB 2202	Amendments to law re radiation therapists	Support	Passed
SB 2927	Rights of Recipients of Mental Health Services	Support w/ amendments	Passed
SB 3003	Restricts tolling of Statute of Limitations in cases filed with Medical Claim Conciliation Panels	Support	Passed
HB 587	Requires the DOH & DOF to coordinate Mental Health Services	No Position	Passed
HB 1979	TB exam requirements for school entry	Support	Passed
HB 2964	Penalties for Medicaid Fraud	No Position	Passed
SB 2741	Fitness to proceed	Support	Passed
SB 2744	Insanity defense	Opposed	Passed
HB 2994	Emergency Medical Services	Support w/ amendments	Passed

A tentative listing of bills which HMA might consider introducing in 1981 include:

- 1) Statewide Medical Examiner System
- 2) Amendments to the Medical Tort Law including periodic payments, collateral sources, payment for medical claim conciliation panel members, etc.
- 3) Repeal of portions of the certificate-of-need law affecting the private practice of medicine
- 4) Use of current physician profiles in Medicaid
- 5) Enable the Department of Labor to publish an RVS
- 6) Amendments to the Podiatry Practice Act
- 7) Additional staff support for the Board of Medical Examiners to handle consumer complaints or review system
- 8) Fluoridation of water supplies
- 9) Motorcycle helmet safety
- 10) Prohibit fiber implantation into the scalp

The budget request is listed below. The budget request for a legislative counsel is for the retaining of legal counsel on a piece-work-as-needed basis for as yet unidentified measures. The entertainment fund is for possible expenses which may be necessary to get into the good graces of key legislators.

<i>Budget Request:</i>	
Lobby/Legal Counsel	\$1,000
Dinner/Entertainment	2,500
	<u>\$3,500</u>

- Recommendations:*
- 1) That the budget of the Legislative Committee be approved as submitted.
 - 2) That Jon Won's efficient services as lobbyist be acknowledged and that he continue in the same capacity for the HMA, and that his regular work load be curtailed during the legislative session so that he can devote his undivided attention to the measures assigned to him by the chairman of the Legislative Committee.
 - 3) That Becky Kendro's invaluable services to the Legislative Committee be acknowledged and that she continue to serve in this capacity.

GEORGE GOTO, M.D.
Chairman and Commissioner

Commission on Peer Review

ACTION: Approved as amended, with referral of the recommendation of the Maternal and Perinatal Mortality Study Committee to the HMA Council for study and action.

At the present time, this Commission includes the Peer Review Committee and the Maternal and Perinatal Mortality Study Committee. Recently, the Council voted to reactivate the Alternative Health Care Practices Committee which will also be under this Commission.

The Peer Review Committee met with legal counsel to review the peer review portions of county society bylaws and the present HMA bylaws. Recommendations for changes have been forwarded to the appropriate bodies.

The Maternal and Perinatal Mortality Study Committee met regularly to discuss and evaluate care in cases selected by its subcommittee. A total of 1 maternal and 23 perinatal cases were reviewed.

ANN B. CATTS, M.D.,
Commissioner

Maternal and Perinatal Mortality Study Committee

The subcommittee (Steering) and main committee met monthly for a total of two meetings a month. A total of 57 cases were reviewed by the subcommittee and 24 were submitted for review by the main committee.

Reassessment of the Committee's function was done. A survey was taken from all of the states and territories as to their perinatal and maternal review process. Reaffirmation of the Committee's educational purpose, rather than punitive action, was agreed upon. Because this is the only review committee at the state level, continued evaluation of all cases, even though there may be some duplication, was thought to be necessary.

There are two problems that have been encountered. The first is funding for educational action on the part of the Committee by such things as meetings on neighbor islands. The second problem is obtaining medical records from cases which may be involved in litigation even though we have a state law protecting the confidentiality of the Committee's proceedings.

On the national level, renewed efforts are being made by Frederick J. Hofmeister to establish a national maternal mortality review organization. Dr. Gordon Ontai was our state representative to this meeting held in conjunction with the American College of Obstetricians and Gynecologists Annual Meeting in May 1980 in New Orleans.

The main committee, Maternal and Perinatal Mortality Study Committee, was accredited for continuing medical education, Category I, by the HMA/CME Committee on April 17, 1980 on an hour-for-hour basis for the monthly evening meetings for a period of one year.

Recommendation:

That funding be made available for four committee members to make a trip to Hilo/Kona, Lihue, and Wailuku during the next year for purposes of education.

LOCKWOOD YOUNG, M.D.
Chairman

Hawaii County Medical Society

ACTION: Filed.

Achievements of the Hawaii County Medical Society (HCMS) would seem to be the effort in consolidating membership with a hopeful gain in active members after several years of declining membership. However, our roster continues to represent a decline in the percentage of active physicians on the Big Island who belong to HCMS.

Bi-monthly meetings were held. Generally, emphasis was on community health topics and political awareness subjects with deliberate effort to encourage physicians' participation in the political and legislative process.

AMA-ERF received support from two fund raising activities sponsored by the HCMS Auxiliary.

Hawaii County Medical Society's Scholarship Fund continues to provide partial support for four medical students from the local community.

JAMES T. LAMBETH, M.D.
President

Honolulu County Medical Society

ACTION: Approved as amended.

As the 1980 president of the Honolulu County Medical Society (HCMS), it was my privilege to work with many concerned physicians wanting to improve medical care, resolve problems facing our Society and improve the image of the physician. Communication with our membership has improved by specialty representation on the Board of Governors, as started by Dr. Patrick Walsh. Business of the Society was easier to conduct, and general membership meetings have been held more to inform members of the pressing social problems we all face. Nevertheless, a general membership meeting will be necessary in the next year to approve significant revisions presently being made in the Society's bylaws.

Although the budget remained balanced, there will be a need to increase dues, not only because of inflation, but also to support further activities planned by the Society, and to have a reserve fund for future needs. Raising dues may not be necessary if more physicians are encouraged to join and pay their fair share to support this organized effort. Members have been informed of the activities of the HMA and AMA at our September meeting, and further financial support for their many activities will be necessary and should be met by increasing membership. Before seeking new members, benefits of membership have to be improved. Several actions have been started:

- 1) No peer review for non-members, unless requested by DSSH or Board of Medical Examiners. Claims from patients against non-members will be referred to proper state organizations.
- 2) Propose to identify members and our purpose in the yellow pages of the telephone directory.
- 3) Tabulation of CME credits only for members.
- 4) Consideration of reduced rates for members for utilizing Professional Medical Practice Management Consultation services offered by the Physicians Exchange.
- 5) General membership meetings of pertinent social, professional, and economic concern.

General membership meetings were held almost monthly on the first Tuesday of each month. These meetings will be held routinely and hopefully, more members will remember the old habit of attending monthly meetings (as in the good old days). The annual meeting will be held in December; and to maintain a tradition, inauguration of new officers, presenting the next year's budget, and honoring life members

will be done. Meeting subjects this year have included legislation, DSSH, taxation, drug abuse, blood bank, and HMO. Future subjects considered presently include SHPDA, IPA, negotiations, medical-legal seminars, and manpower. Attempts were made to briefly summarize these meetings for our members.

Your BME has been effectively servicing physicians while respecting patients' rights and ability to pay. The Physicians' Exchange remains stable with new ideas and services planned. Its program for organizing and starting an office practice, to include billings, has been rapidly accepted.

Future problems and goals to be considered include:

- 1) Study of physician manpower
- 2) Increased peer review activities with DSSH and even HMSA
- 3) Increasing medical-legal committee activities and goals
- 4) Consider medical legislation, not only for the benefits of medicine, but on a social level to include helmets for motorcycle riders again, quackery, seat belts, and smoking in public places.

I wish to thank my fellow officers, the members of the Board of Governors, members who have served on committees, and our executive staff for all the efforts devoted to HCMS activities this past year. Comments have been received by phone and in writing from our members and are being encouraged.

CALVIN C. M. KAM, M.D.
President

Kauai County Medical Society

ACTION: Filed.

The Kauai County Medical Society has had an active year, having met in January, April, July, and August as of this writing. Guests of the Society at the informative meeting in April were HMA representatives, President Dr. Douglas Bell, Executive Director M. Jonathan Won, and Staff Liaison Person Mrs. Bess Chang. At the August membership meeting, the Society had Dr. Michael Dang, vascular surgeon from Honolulu, as guest speaker.

It is gratifying to see a rise in membership in the Kauai County Medical Society this year.

ROBERT J. HAMBLIN, M.D.
President

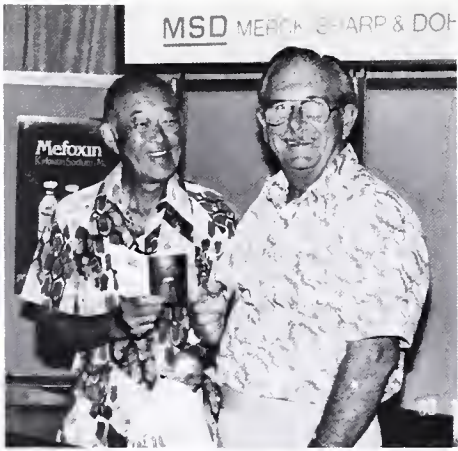
Maui County Medical Society

ACTION: Filed.

The Maui County Medical Society has enjoyed a fruitful year. I thank Dr. Eugene Wasson, Vice President, and Dr. Michael Savona, Secretary-Treasurer, for their support.

This year's goals were in areas to provide health awareness to the community, to strengthen our Medical Society, and to communicate with other related health professions and our legislators. Some of the highlights in achieving these goals were as follows:

- Joint meetings with the pharmacists in January, with our Mayor Hannibal Tavares in May, and the dentists and state legislators in July.
- In March, Doctors Marion Hanlon, William Gintling, William James, William Mitchell, Donna McCleary, Edgar Auerswald, Robert Bjornson, and Gary Salenger all participated in the Maui Celebration presenting a "Forum on Health and Wellness."
- A Public Relations Committee has been set up to provide articles relating to health in the Maui newspaper as well as to provide speakers to any Maui community organization wishing to hear talks on health.
- For our physicians, we devoted a Medical Society meeting and hospital staff meeting for a course in Continuing Medical Education with Category I credit.
- For the enjoyment of our members and spouses, our annual Christmas dinner meeting will be a south seas island buffet at the Hyatt Regency on December 6.





Hopefully, by the end of this year, the Maui County Medical Society will be incorporated. The incoming officers will continue to give strong support to the Hawaii Medical Association.

ANDREW DON, M.D.
President

Leadership Conference Committee Report

ACTION: Approved with adoption of the four basic missions as outlined in the report.

The 1980 Leadership Conference took place at the Ilikai Hotel, August 9-10, 1980. Approximately 75 physicians attended during the two-day session. The basic reason for this leadership conference was to determine the appropriate roles and functions, and the future direction of, the Hawaii Medical Association in the medical and health community as well as in the community at-large. This leadership report is presented to the HMA House of Delegates for review, discussion, modification if desired, and, hopefully, adoption of an agreed-on set of directions which would provide, not only HMA leadership, but the entire membership, as well, clear and concise statements of the missions of the HMA for the years to come, and those strategies that would be utilized each year to accomplish the established missions.

Five reference panels, dealing with the broad issues and topics of: (1) financial management; (2) government affairs and research; (3) internal management; (4) communications and public relations; and (5) medical service and education, convened during the first day of the conference to receive oral testimony from HMA members, non-member physicians, voluntary health organizations, community organizations, lay groups, etc., and to review written testimony submitted. These panels deliberated all of the issues and concerns presented and prepared a report for a general session the next day. The general session of physicians received the reference panel reports, discussed each item, and generally agreed that it would recommend to the HMA House of Delegates that it adopt four basic missions for the HMA:

- I. MAINTAIN OPTIMAL QUALITY OF CARE IN OUR COMMUNITY
- II. STRENGTHEN ORGANIZED MEDICINE
- III. REPRESENT THE MEDICAL PROFESSION
- IV. MAINTAIN EFFECTIVE COMMUNICATION WITH THE PROFESSION AND THE PUBLIC

The idea behind the adoption of these missions is three-fold: (1) that all programs and activities of the Hawaii Medical Association would be considered for implementation in the context of meeting one of the four missions; (2) that all programs and activities existing and/or proposed would be considered for implementation funding based on the priority of the program or activity and the resources available; and (3) that physicians could reply to the question, "What does HMA stand for?"

The discussion during the two-day conference also generated ideas, or strategies, for accomplishing each of the agreed-upon missions. The strategies for each of the missions are listed below following this report. These strategies would be reviewed each year by the HMA Council and the HMA House of Delegates to assure ourselves that each strategy still had a proper place within the context of the HMA, and strategies that no longer served an appropriate purpose could be deleted, and new strategies considered more appropriate could be adopted. Your Leadership Conference Committee recognizes that many of the strategies under the four Missions are duplicative; however, we recognize also that the overlaps are necessary and important in the context of the entire Association and its activities.

HMA staff has taken the proposed missions and strategies, existing programs and activities within the HMA, and the ideas generated and discussed at the Leadership Conference and has further established a listing of existing and proposed activities and programs under each of the strategies that are or could be used to implement the strategy. It is the desire of your Leadership Conference Committee that this House of Delegates adopt the four basic Missions for the HMA; to adopt, as a working document, the various

strategies listed under each Mission; to have the HMA Council determine a mechanism for review and study of each strategy and the draft of existing and proposed programs and activities, and to begin work toward formalizing the programs and activities that your HMA will utilize to implement each accepted strategy.

Recommendations:

Based on this background, your Leadership Committee recommends to the HMA House of Delegates, that it:

- I. Adopt as Missions for the Hawaii Medical Association:
 - a. MAINTAIN OPTIMAL QUALITY OF CARE IN OUR COMMUNITY
 - b. STRENGTHEN ORGANIZED MEDICINE
 - c. REPRESENT THE MEDICAL PROFESSION
 - d. MAINTAIN EFFECTIVE COMMUNICATION WITH THE PROFESSION AND THE PUBLIC;
2. Adopt, as a working document, the strategies for each mission as presented;
3. Instruct the Council to establish a mechanism that would implement determination of programs and activities under each strategy;
4. Utilize the documents and materials developed by the 1980 Leadership Conference in accomplishing the task;
5. Instruct the President to report back to the House of Delegates at its next Annual Meeting on the progress of implementation.

DOUGLAS B. BELL, II, M.D.
Chairman

STRATEGIES

MISSION I

Maintain Optimal Quality of Care in our Community

Strategies

- 1) Public Education
- 2) Professional Education
- 3) Scientific Program
- 4) Peer Review (cost-effective)
- 5) Impaired M.D.
- 6) Strengthen Interprofessional Relations
- 7) Strengthen Government/Community Relations
- 8) Assure public's health and environment
- 9) Strive for fiscal realities in health care

MISSION II

Strengthen Organized Medicine

Strategies

- 1) Training and Orientation
- 2) Evaluation, Justification, Prioritizing of Activities
- 3) Documentation of policies and positions
- 4) Coordination with support of county societies
- 5) Effective information and reference system
- 6) Effective, efficient financial support/analysis system
 - a) balanced budget
 - b) build cash reserves
 - c) 2 year operating budget
 - d) 5 year capital expense budget
 - e) allocated costs
 - f) alternate sources of revenue
- 7) Provide Socioeconomic Policies and Information
- 8) Promote effective delivery of health care

MISSION III

Represent the Medical Profession

Strategies

- 1) Legislative Action and Lobbying
- 2) Health Care Costs
- 3) Public Education
- 4) Professional Education
- 5) Legal
- 6) Health Care Planning
- 7) 3rd Party Relationship
- 8) Negotiations
- 9) Advisory Consultation in community
- 10) Government Community Relationships
- 11) Relationships with other Health Care providers

MISSION IV

Maintain Effective Communication with the Profession and the Public

Strategies: Professional

- 1) Professional information and education
- 2) M.D. community involvement
- 3) Membership recruitment and retention
- 4) Member benefits and services
- 5) Organizational image
- 6) Public involvement
- 7) Student/house staff relations

Strategies: Public

- 1) Public health education
- 2) Media relations
- 3) Organizational image
- 4) Business/labor relationships
- 5) Positive policy promotion
- 6) Health-related agency relations

Medicaid (ad hoc)

ACTION: Approved.

The Medicaid Committee had an active year, primarily in pursuit, and happily partially successful, of an increase from the Legislature for professional provider reimbursements under the Medicaid Program in the second half of the legislative biennium. If you will recall, in the prior year on Easter Sunday night, the Conference Committee on the Budget slashed the provider portion of the Medicaid budget for the biennium by \$8,000,000 for the first year and \$7,000,000 for the second year, leaving us stuck at 1975 profiles and in consequence, leaving in place the inequities of greater reimbursements to doctors who did not have profiles in 1975. We were successful in achieving a \$4,000,000 increase for the year which was calculated by HMSA to be equivalent to 79% of the 75th percentile of 1979 profile data. We were successful in convincing the Legislature to stipulate the most recent 1979 profile as the data base for reimbursement. This should largely eliminate discrepancies between physicians of different practice ages.

Of course, with Medicaid's disallowance of a differential levels of initial or follow-up office visits, inadequate reimbursement of expenses for office supplies consumed, and other arbitrary rulings, the physician's net income from Medicaid will not approach 79% of last year's fees even if the fee profile did not go above the 75th percentile. To prepare for the legislative program we polled the membership for data, compared the Medicaid reimbursements with Medicare, Worker's Compensation, and private insurance reimbursements, met with allied professions and began a hard lobbying effort with key legislative members. Testimony was prepared for presentation at a major hearing on the Medicaid Program by the House Human Services Committee and for hearings in front of the House and Senate Health Committees. We introduced bills that would have mandated the Legislature's use of the most current profile data from the preceding calendar year and determine what level of that profile to fund and the required use of the revised RVS data that we have prepared but not yet published. This bill was unsuccessful, primarily because the Legislature wanted no part of anything that appeared to imply automatic increases in funding, a politically sensitive issue in regard to some public employee contracts.

We also had meetings with Mr. Chang and Mr. Millar, the Medicaid administration, trying to get their support for more adequate reimbursements and seeking to make the Medicaid administration more open to provider input and to assist in peer review of early suspected provider misunderstandings or abuses of the program. There remains great reluctance on the part of Medicaid administration to accept any of this, or to have any faith that we would do anything effective to curb abusing providers. Medicaid Committee Chairman was privileged to be able to attend an AMA sponsored National Workshop on State Legislative issues held in Arizona at the beginning of the year. This was very valuable in perspective of our problems with other states.

Outlook for Future and Recommendations for Action for Next Year's Medicaid Committee

Several factors make the next year in the Medicaid Program of fairly crucial import.

1. The Medicaid Provider Handbook has been severely criticized and the rules do not follow uniform regulation format of the State. Therefore, the entire Medicaid Provider Manual is being revised with rewrite of all the rules. It is essential that we achieve input to try to correct some of the highly discriminatory rules that create so much friction between providers in the program. It should be noted that the administration has never come out with revised Rule 8 upon which there was public hearings in 1980 which demanded a formal contract signed with each "grandfathered physician" serving the Medicaid Program. Physicians entering the program in recent years have had to sign agreement contracts with the Medicaid Program in order to be reimbursed whereas older physicians were "grandfathered" into this without a signed formal contract.
2. The Medicaid Program is essentially leaderless at the present time. They have always been woefully understaffed. They have abandoned many administrative responsibilities to HMSA, but HMSA as a contracting agency to the State does not have any authority to deal directly with the providers, other than in following rules laid down by the Medicaid Program. Hopefully, the legislators (who are aware of the leadership vacuum and the competition of other very serious problems in the Department of Social Services and Housing for leadership attention, will result in some changes in this regard.)
3. The fiscal intermediary contract is going out to bid this year, and the suspicion is that if we have trouble with HMSA's administration, we will have it in spades if the whole operation moves outside the State.
4. We recommend that next year's Medicaid Committee continue to push hard for more active input and communication with the State administration, trying to develop some faith in our professional integrity and willingness to work together to make the Medicaid Program successful. This particularly goes for a role in attempting to assist in early guidance and counseling of any errant providers before a situation deteriorates requiring prosecution for fraudulent abuse of the program.
5. The real struggle due to the current structuring of the law of any Medicaid Committee will be directly with the Legislature to secure each year the use of an updated profile and increasing appropriations to maintain an adequate level of Medicaid reimbursement. I doubt that we can ever achieve the maximum reimbursement allowed under Federal rules, which is the 75th percentile of usual and customary fee profile. If we could get the Legislature to buy 85 or 90% of this on a constituent basis, we would be as well off as we could achieve.

E. LEE SIMMONS, M.D.,
Chairman

Medical Ethical, Moral, and Legal Concerns

ACTION: Approved with the exception of recommendation no. 3.

The Committee has broadened its scope and membership to include representatives from the fields of law, nursing, medical technology, theology, and philosophy. During the reorganization period, two priority areas were identified: education and counseling services. Guidelines were developed for panels to assist family/patient and health providers in the decision-making process. Programs are needed to inform, alert, and stimulate the medical and paramedical professions concerning the complex problems arising from rapidly advancing technology. The Committee has begun the ground-work to encourage and/or provide such programs. It

will be necessary to enlist the support and cooperation of many community agencies and professional disciplines to assist in ensuring that the ethical and moral implications of medical practice are not overwhelmed or obscured by scientific enthusiasm. The Committee has really just begun to address some of the concerns in this area and recognizes the urgent need to educate its own members to serve as a catalytic core.

Recommendations:

- 1) That this Committee be made a standing Committee of the HMA, directly responsible to the Council.
- 2) That a program regarding medical ethical, moral, and legal concerns be included in the 1981 Annual Meeting, and that county societies be encouraged to devote one of their meetings to the subject during the coming year.
- 3) That a budget of \$1,500 be provided for the expenses of a committee physician member to attend a mainland meeting/seminar and/or authority in this area to visit.

ANN B. CATTS, M.D.
Chairman

Medical Malpractice Insurance Law (Ad Hoc)

ACTION: Approved as amended.

The Medical Malpractice Insurance Law Committee was charged with the task of determining the need for amendments to the Medical Malpractice Insurance Law, to review the availability of malpractice insurance in the State, and to determine what might be done to encourage competition and lower insurance rates. In addition, the Committee was asked to assume the responsibility for the sponsorship of a Malpractice Insurance Crisis Committee of interested physicians, physician groups, hospitals, and other facilities to petition for a rate review hearing before the Hawaii Insurance Commissioner and to raise funds as needed for such a petition (1979 House of Delegates, Resolution No. 3).

The Committee has met regularly since November of 1979 and has focused primarily on the establishment of the Malpractice Insurance Crisis Committee and rate review hearing. The Committee agreed in February 1980 that in order to proceed with a rate hearing, it would be necessary to determine how much financial support could be raised to cover the legal costs expected for such an endeavor. Letters soliciting pledges were sent to all physicians in Hawaii, as well as to all hospitals. In April 1980, it was believed that we had received the necessary pledges to proceed. Following the May 1980 Council meeting, the Committee interviewed Attorney John Edmunds and contracted with him to represent the Association in the rate review process. Attorney Edmunds and his associates have done preliminary research including a trip to Pennsylvania to confer with attorneys who represented physicians in a similar rate review process. Mr. Edmunds has provided the members of the HMA with a lengthy opinion letter and suggested action plan.

The cost of proceeding with a full rate review hearing will necessitate the accumulation of a fund somewhere between \$20,000 to \$60,000. While the Committee agrees that we should continue to solicit voluntary contributions to this fund, it appears unlikely that we would be able to achieve this amount. The Committee, therefore, recommended to the HMA Council that an assessment be levied on all HMA members in the amount of \$75.00. At the September 5 Council meeting, the Council voted to recommend the referral of this matter to the floor of the House of Delegates for favorable consideration. Since the Council meeting, letters have been sent to the HMA membership and to non-members soliciting additional contributions; to date the Committee has received \$12,500 for this fund with expenses of approximately \$9,000.

It is therefore, our Committee's recommendation that the House of Delegates approve:

That the HMA Council be authorized to utilize up to \$60,000 of the Association's reserve funds, but that the Committee make every effort to secure the needed funds on a voluntary contribution basis before such reserve funds are utilized.

Copies of the legal opinion, as well as correspondence with the HMA membership is on file in the HMA Office.

PHILIP HELLREICH, M.D.,
Chairman

Self-Insurance (Ad Hoc)

ACTION: Approved

This Committee did not meet during the year 1979-80. There are no recommendations.

JOHN W. EDWARDS, JR., M.D.,
Chairman

Resolution No. 1

ACTION: Adopted

Re: Hawaii Medical Association Honorary Membership for Donovan F. Ward, M.D.

WHEREAS, Dr. Donovan F. Ward has distinguished himself as a Past President of the American Medical Association and,

WHEREAS, he has devoted timeless effort to the Hawaii Medical Association and its component societies on different occasions and,

WHEREAS, he has recently completed 50 distinguished years in the practice of medicine and surgery and will shortly retire from this endeavor, so be it

Resolved, that the Hawaii Medical Association grant Donovan F. Ward, M.D., an Honorary Membership with all the privileges, thereby accorded to that status.

DENIS J. FU, M.D.

Resolution No. 3

ACTION: Adopted as amended

Re: Specialty Subcommittees Under HMA Peer Review Committee

WHEREAS, the Hawaii Medical Association and its component county medical societies are increasingly being asked to conduct peer review on physicians; and

WHEREAS, the advent of medical and surgical specialization has created a need in the medical community and community-at-large for specialty and subspecialty peer review; and

WHEREAS, HMA legal counsel has rendered an opinion that peer review committees under specialty or subspecialty societies does not fall under the protection of Hawaii law as a duly constituted professional peer review system; and

WHEREAS, more and more governmental agencies are entering more actively into areas which should be in the realm of peer review; and

WHEREAS, the HMA should take affirmative steps to provide true and effective peer review; and

WHEREAS, the neighbor island county medical societies do find, from time to time, that it is unable to conduct objective peer review; now, therefore, be it

Resolved, that the Bylaws of the HMA be instructed to provide language for an amendment to the appropriate section or sections of the HMA Bylaws, which would allow for the creation of subcommittees under the HMA Peer Review Committee for all types of specialties and subspecialties; and be it further

Resolved, that such subcommittees may be formed under the HMA Peer Review Committee at the request of duly recognized specialty and subspecialty organizations, groups, or associations in the State of Hawaii; and be it further

Resolved, that the HMA Bylaws Committee and the Peer Review Committee report to the HMA Council on its deliberations and recommendations by January 1, 1981, and be it further

Resolved, that the HMA Council review such recommendations of the HMA Bylaws Committee and determine whether or not a special session of the HMA House of Delegates would be in order to consider such Bylaws amendments.

NEAL E. WINN, M.D.

Reference Committee on Finance and Administration

HMA Auxiliary

ACTION: Approved with the recommendations that membership in the HMA Auxiliary be on a voluntary basis rather than on an automatic basis, and that the Auxiliary change its fiscal year to conform with the HMA's fiscal year, which is a calendar year.

During the past year, the State Auxiliary President has attended monthly HMA Council meetings; it has been an opportunity to relay the purposes and activities of the Auxiliary. Those purposes came under close scrutiny when it was necessary to request increased funding due to the raise in National dues. This necessitated the Auxiliary to carefully evaluate our value as an Auxiliary and set priorities in program funding. Top priority was given to the continued support of the National Auxiliary. Extensive testimony was presented to the HMA Council and the 1979 House of Delegates' Finance Committee; happily the increase was granted.

The AMA Interim Delegate meeting in Honolulu offered an opportunity for local members to communicate with National officers: AMAA President, President-elect, Treasurer, and Executive Director. AMA President, Dr. Gardner, and AMAA Legislative Chairman addressed an Auxiliary sponsored joint Medical Society legislative meeting. Immediately following, a general membership mailing was used to urge members to become involved in legislation and attend a joint Auxiliary/Medical Society legislative workshop organized by our state Legislative chairman. Grass root support of the candidates was urged, and our legislative chairman was instrumental in helping key legislators with campaign fund raising as well as following major health bills.

Our Counties have not been unanimous in supporting AMA-ERF; however, efforts were expended for various worthy causes. Hawaii County raised \$2,000 in AMA-ERF contributions with game nights and dinners; Kauai also contributed with a volleyball-bridge tournament. Maui County provided two scholarships for their native sons attending the University of Hawaii Medical School. At the request of the Honolulu County Medical Society, Honolulu Auxiliary gave a gala auction-dinner benefit which netted \$7,000 for the Hawaii Medical Library.

In the area of health services, Hawaii County continued its participation in the blood bank program and CPR instructions. It also started a new program of display racks in physicians's offices, with health information obtained from the public health department, as one source. Maui Auxiliary decorated labor rooms at the Maui Memorial Hospital and participated in the Wellness Celebration with the "Forum on Health and Wellness." Honolulu Auxiliary's 15th annual "Guest Day" seminar, "Fractured Families, What Happens to the Kids?", attracted wide community attendance with news coverage both before and after the event. The National Auxiliary's two year "Shape Up For Life" theme was highlighted by a doctor and wife team's presentation on diet and diseases. The joint Honolulu County Medical Society and Auxiliary's awareness program to encourage seat belting children was highly successful. During Seat Belt Week, hundreds of bumper stickers were distributed, articles appeared in local newspaper and hospital publications. We were gratified to see a report of our efforts appear in the AMA Auxiliary's publication, FACET. All over the State, we have seen evidence of the fulfillment of Auxiliary's goals with numerous educational and service projects.

MRS. MAY KIM
President

Building

ACTION: Approved with the recommendation that the Building Committee be appointed by the President with Council approval.

The Building Committee of the HMA has met only once during the past year; however, this one meeting established a

much better understanding and purpose of the Building Committee that will make it a more responsive committee than in the past. Usually, due to constraints of neighbor island physicians on the Committee, meetings were scheduled just prior to the Council meetings this, however, meant that only 30 to 45 minutes could be spent on building matters. There is a recommendation contained in this report which modifies the Building Committee composition and terms of office which your Building Committee feels is extremely wise.

The building at 320 Ward Avenue continues to hold its own financially. It appears that for the 1980 calendar year, budget projections will hold, meaning that the building should experience a positive cash flow for the year. As in past years, the building at 320 Ward Avenue has been virtually 100% occupied throughout the year. In reviewing past policy of the Building Committee, it was determined that the minimum rental in 320 Ward Avenue should be \$1.25/sq. ft./month to reflect going rates in the community for comparable buildings. After-hours air-conditioning charges, which have been at \$4.00/hour since 1975, have been adjusted to \$10.00/hour to reflect drastically rising energy costs. The parking lot company retained appears to have stabilized the parking situation such that physicians can find parking available to them. During the past year, there have been two new major tenants with two current tenants expanding their office space. The budget for 1981 for the building is presented with this report, and you should notice that the budget projections for 1981 are vastly improved over the 1980 budget projections and actual experience. One must keep in mind, however, that the land lease rent is due for renegotiations in late 1981, which should add a significant amount to our costs. Your Building Committee will look toward your interests in looking after your building.

Recommendations:

- 1) That the Building Fund Budget be approved as submitted.
- 2) That the Building Committee be established as a 5-member committee, with 5 year staggered terms, and that the initial committee appointments be for terms of 5, 4, 3, 2, and 1 year terms.

DOUGLAS B. BELL, II M.D.,
Chairman

Commission on Internal Affairs

ACTION: Approved as amended, with the exception of proposed amendments to Bylaws Section 8.124 and proposed Bylaws additions, Sections 4.021 and 5.018. With regard to proposed amendments to Section 8.124, it was recommended that the matter be re-evaluated by the next House of Delegates. The Delegates recognized the value of the concept of the proposed Sections 4.021 and 5.018 and recommended that the HMA Council investigate these proposals and submit a report to the 1981 House of Delegates.

The Commission on Internal Affairs includes the Arrangements Committee, the Bylaws Committee, and the Program Committee. The reports of these committees are printed below.

K. Y. LUM, M.D.
Commissioner

Arrangements

Members of this Committee met several times during the year to plan the 124th HMA Annual Meeting to be held at the Pacific Beach Hotel, October 12-17, 1980. While this Annual Meeting has been held in the past in conjunction with the AMA Regional CME Meeting, the AMA is unable to participate this year for financial reasons. The AMA does plan to participate in our meeting next year and hopes to do so on an every-other-year basis in the future.

Arrangements for the meeting and the scientific program have been made under the supervision of the Convention Chairman, Dr. Herbert Uemura. Several postgraduate courses approved for CME credit have been scheduled for

each morning, Monday through Friday, October 13-17. Additionally, a full day course on medical practice management for medical assistants has been scheduled for Sunday, October 12; a course on Computerized Electrocardiography—"The Physician's Assistant" has been scheduled for Monday evening, October 13; and half-day courses for physicians on "Joining a Group or Partnership" and on "Closing A Medical Practice" have been scheduled for the afternoons of Tuesday, October 14, and Friday, October 17, respectively.

Booths for exhibitors will be open on Monday, Tuesday, and Wednesday mornings and during a special wine and cheese reception planned for all registrants, exhibitors, and guests including medical students and housestaff.

A number of tournaments including a skin diving tournament, a deep sea fishing tournament, a ping pong tournament, a tennis tournament, and a golf tournament have all been scheduled with plans to honor the winners at the Annual Sportsmen's Night Party scheduled on Thursday, October

16, in the Cathay Room of the Hilton Hawaiian Village's Golden Dragon Restaurant. The HMA's Annual Banquet, "Ahaaina Piha Makahiki," featuring a superb dinner and outstanding Hawaiian entertainment by Palani Vaughan have been planned for Friday, October 17, in the Oceanarium Ballroom of the Pacific Beach Hotel. The opening session of the HMA House of Delegates is planned for Monday, October 13, with the final meeting of the House of Delegates planned for the afternoon of October 15, 1980. Dr. Robert B. Hunter, President of the American Medical Association, will be our special guest.

In accordance with the wishes of the Arrangements Committee and the approval of the HMA Council, the Annual Meeting for 1981 to be held in conjunction with the AMA Regional CME Meeting, has already been scheduled for the week of October 11, 1981. It will be held at the Ilikai Hotel.

Hawaii Medical Association—Building Fund
1981 Budget

	Current Yr. 1980 6 - Months	1980 Estimated	1980 Budget	1981 Budget
Income:				
Rent—Lease	67,763	135,526	145,893	186,258
Rent—Parking	620	1,240	13,116	18,600
Other—Interest	119	238	1,000	1,000
TOTAL INCOME	68,502	137,004	160,009	205,858
Expenses:				
<i>Owner's Expenses:</i>				
Building Repair & Maintenance	- 0 -	- 0 -	5,000	12,200
Insurance	- 0 -	- 0 -	360	420
Electricity	850	1,700	1,844	2,460
Commission—Leasing	1,219	2,438	2,438	1,800
Professional & Legal	166	332	600	- 0 -
Lease Rent	19,740	39,480	39,480	48,360
Interest	32,482	64,964	64,943	61,236
Depreciation	17,209	34,418	32,896	34,092
Miscellaneous	9	18	120	600
TOTAL OWNER'S EXPENSE	71,675	143,350	147,681	161,168
Common Area Expenses:				
Bldg. Repair & Maintenance	8,004	16,008	8,316	9,840
Landscape Maintenance	4,030	8,060	8,400	8,400
Janitorial	5,796	11,592	12,072	11,750
Contract Repairs	- 0 -	- 0 -	1,596	1,800
Maintenance Supplies	3	6	4,200	5,400
Air Conditioning	5,837	11,674	9,504	8,304
Parking	5,868	11,736	13,800	12,000
Refuse	383	766	888	1,030
Pest Control	240	480	372	480
Electricity	14,234	28,468	29,327	42,000
Water	1,660	3,320	3,900	3,720
Management Fees	4,992	9,984	9,984	12,000
Insurance	1,887	3,774	3,360	3,360
General Excise Tax	3,236	6,472	7,267	6,700
Miscellaneous	24	48	- 0 -	240
TOTAL COMMON AREA EXPENSES	56,194	112,388	112,986	127,024
Recoverable Expenses:				
Real Property Tax	6,195	12,390	12,500	13,638
Assessment	3,955	7,910	4,000	- 0 -
TOTAL RECOVERABLE EXPENSES	10,150	20,300	16,500	13,638
Direct Recoveries:				
CAM Recoveries	15,839	31,678	7,800	22,224
Real Property Tax	3,113	6,226	6,800	8,586
Assessment	66	132	2,800	- 0 -
TOTAL DIRECT RECOVERIES	19,018	38,036	17,400	30,810
TOTAL EXPENSES	119,001	283,002	259,767	271,020
NET INCOME—INCREASE (DECREASE)	(50,499)	(100,998)	(99,758)	(65,162)

I wish to thank the members of the Committee for their assistance in planning and coordinating the various events and tournaments held in conjunction with the Annual Meeting.

NEAL E. WINN, M.D.
Chairman

Bylaws

The Bylaws Committee met on two occasions to prepare amendments to the Bylaws which were suggested by the HMA Officers, the Council, and the 1979 House of Delegates. The Committee also prepared amendments to implement past actions of the House.

The Committee respectfully submits the following as proposed amendments to the Bylaws: (Note: additions are capitalized or underscored, deletions made with hyphens)

2.00 MEMBERSHIP

2.01 Every member in good standing of a component society of this Association shall be a member of this Association and the American Medical Association, either as an active, special, or service member. Membership in the Hawaii Medical Association or in any of its component societies shall not be denied or abridged on account of color, creed, race, religion, SEX, or ethnic origin.

2.05 Special members. Special membership shall be limited to those members of the component societies of this Association who are special members in their component societies. They shall have the same rights, ~~and~~ privileges, AND RESPONSIBILITIES as active members ~~except the right to hold office~~. The eligibility of such members shall be reviewed at least annually. Dues for special members of this Association shall be not less than one-third of the dues of active membership. They may apply for active membership if properly qualified.

2.082 Any person whose name has been dropped from the membership roll of a component society shall not be entitled to any of the privileges or benefits of membership, ~~nor shall he be permitted to take part in any of the Association's proceedings.~~

2.084 All active, special, and service members of this Association shall subscribe to the HAWAII MEDICAL JOURNAL. MEMBERS WHO ARE NO LONGER CHARGED DUES, FOR WHATEVER REASON, ARE ENCOURAGED TO SUBSCRIBE TO THE HAWAII MEDICAL JOURNAL AT THEIR OWN EXPENSE.

2.085 All members of this Association shall be either active or ~~associate~~ SPECIAL members of the American Medical Association. The Secretary of this Association shall certify the members for enrollment in the American Medical Association.

4.00 HOUSE OF DELEGATES

4.02 Special Representatives: A seat shall be provided in the House of Delegates for one delegate elected by the ~~Hawaii Chapter of the Student American Medical Association (SAMA) and for one delegate elected by the Hawaii Association of Interns and Residents, who shall be accorded the privilege of the floor with a vote,~~ STUDENT BODY OF THE UNIVERSITY OF HAWAII SCHOOL OF MEDICINE FROM AMONG ITS MEMBERS WHO ARE ALSO MEMBERS OF THE HAWAII MEDICAL ASSOCIATION. THE ELECTED MEMBER SHALL BE ACCORDED THE PRIVILEGE OF THE FLOOR WITH A VOTE. A SEAT SHALL BE PROVIDED IN THE HOUSE OF DELEGATES FOR ONE DELEGATE FROM THE RESIDENT PHYSICIANS IN AN APPROVED RESIDENCY TRAINING PROGRAM IN HAWAII FROM AMONG ITS MEMBERS WHO ARE ALSO MEMBERS OF THE HAWAII MEDICAL ASSOCIATION AND WHO SHALL BE ACCORDED THE PRIVILEGE OF THE FLOOR WITH A VOTE. ~~These representatives shall be members of a component medical society of the Association.~~

4.042 During any meeting of the annual session, the House of Delegates may elect to hold an interim session ~~in the~~

~~last six months of the same calendar year.~~ The time and place of such interim session shall be determined by the Council as far as possible in advance and notice thereof published in the Journal of the Association.

4.096 It shall ~~elect~~ ELECT delegates and alternate delegates to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body.

5.00 THE COUNCIL

5.033 In consideration of the Hawaii Medical Library's service to the members of the Association, ~~it shall~~ THE ASSOCIATION MAY assist in the financial support of the Hawaii Medical Library and ~~shall~~ MAY from time to time, and at ~~least once a year,~~ appropriate funds for this purpose, subject to the approval of the House of Delegates.

5.06 Duties. The duties of the Council shall also include the study and supervision of the following activities: (1) all scientific work presented at each annual meeting, (2) scientific exhibits, (3) medical education and post-graduate education, (4) Journal management and publication, (5) medical or related research, (6) arrangements for annual session, (7) preventive medicine and public health, (8) legislation, (9) economics, (10) workmen's compensation, (11) public relations, (12) cooperative relations with Federal and State Governments, foundations, and other lay groups, (13) medical care insurance, (14) any activities not otherwise provided for, (15) the Council shall also keep constantly advised of, and collaborate with, the ~~Health and Welfare departments~~ DEPARTMENT OF HEALTH AND THE DEPARTMENT OF SOCIAL SERVICES AND HOUSING of the State and with hospitals, clinics, and welfare agencies in furthering the health of the residents in the State, and (16) determine the composition of the Association's attendance at the annual and clinical sessions of the American Medical Association.

6.00 SESSIONS AND MEETINGS OF THE ASSOCIATION

6.01 Annual Session. In each year there shall be an annual session which ~~shall~~ MAY consist of (1) a general membership meeting, (2) a scientific meeting, and (3) a meeting of the House of Delegates. The following events if scheduled during the annual session shall become a part of the proceedings of that session (1) banquet, (2) picnic, (3) sports tournaments, (4) hobby, scientific, and commercial exhibits.

6.03 Scientific Meeting.

6.031 The scientific meetings of the Association ~~shall~~ MAY be established to foster the presentation and discussion of subjects pertaining to the advancement of the art and science of medicine and shall be presided over by the chairman of the Scientific Program Committee. SUCH MEETINGS MAY BE HELD IN CONJUNCTION WITH OTHER ORGANIZATIONS SUCH AS THE AMA.

8.00 COMMITTEES AND COMMISSIONS

8.06 Only active or dues-paying special members of the Hawaii Medical Association may serve as voting members of any of its committees or commissions. Waiver of dues constitutes payment of dues. THE COUNCIL MAY, AT ITS DISCRETION, APPOINT NON-MEMBER PHYSICIANS OR LAY PERSONS AS NON-VOTING CONSULTANTS TO COMMITTEES AND COMMISSIONS. (per Resolution No. 3 adopted by 1978 HMA House of Delegates)

8.08 Appointed Committees. The functions and objectives of all appointed committees shall be specified in the Hawaii Medical Association ~~Rules and Regulations~~ POLICIES. ~~They~~ THESE POLICIES shall be kept current by the executive director with the assistance of the respective commissioners and committee chairmen, as approved or amended by the Council.

8.113 Bureau of Research and Planning. (1) The Bureau of Research and Planning shall consist of not less than ten members serving for three-year terms, four being elected each year by the Council for FROM nominees presented by the president of the Association. (2) The chairman shall be appointed by the President with the approval of the Council. (3) It shall be directly responsible to the Council and the President. (4) It may initiate study projects and consider such matters as are referred to it by the President and the Council. (5) After due deliberation and the holding of hearings on a matter, it shall make recommendations to the Council. (6) The Bureau should function as a forward-looking committee with broad viewpoint, to help guide the HMA in its future course and objectives.

8.124 Cancer Commission. (1) There shall be a Cancer Commission whose primary responsibility shall be to act as the administrative and policy making body for the Hawaii Medical Association's Hawaii Tumor Registry. (2) This Commission shall consist of not more than eight SIX physicians, all members of the Hawaii Medical Association. They shall serve for three-year terms. The members of the Commission shall be appointed by the President of the Hawaii Medical Association, two from nominees named by the Council of the Hawaii Medical Association, two from nominees named by the Hawaii Division of the American Cancer Society, ~~two from nominees named by the President of the University of Hawaii from the faculty of the Medical School of the University of Hawaii~~, and two from nominees named by the Director of the Hawaii State Department of Health. The members shall serve staggered terms and their replacements at the expiration of their terms shall be appointed in the same manner and from the same organization as their predecessors. The Cancer Commission's Chairman shall be appointed annually by the President of the Hawaii Medical Association from the members named above. (4) The Commission shall meet at least six times a year and shall submit the minutes of each meeting to the HMA President, the HMA Cancer Committee, the Department of Health, AND the American Cancer Society-Hawaii Division, ~~and the Dean of the University of Hawaii School of Medicine.~~

9.00 FUNDS AND EXPENSES

9.01 Membership Dues.

9.022 PHYSICIANS ENTERING A PRACTICE AFTER THE COMPLETION OF AT LEAST A THREE-YEAR RESIDENCY TRAINING PROGRAM MAY BE GRANTED A REDUCTION IN DUES AT THE DISCRETION OF THE COUNCIL.

9.023 (per action by 1978 HMA House of Delegates)

~~9.022~~ Request for waiver of dues must be confirmed ~~in writing~~ TO THE HMA by the Secretary of the member's component society within 90 days after the beginning of each fiscal year for which the extension of the waiver of dues is requested, ~~except that~~. HOWEVER, THE waiver of dues for a portion of ~~the~~ a calendar year need not be reconfirmed until a full year has passed since the date the waiver became effective.

The Committee also received the following proposed bylaws amendments which were suggested by Dr. George Mills:

1. Add new Section 4.021 (Special Representative to House of Delegates)

A seat shall be provided in the House of Delegates for one delegate to represent the Hospital Association of Hawaii, who shall be accorded the privilege of the floor with a vote. This representative shall be a member of a component medical society and the Association. An alternate delegate, who must also be a member of a component society and the association, may also be named.

2. Add new Section 5.018 (Special Representative to HMA Council)

A seat shall be provided in the HMA Council for one councilor to represent the Hospital Association of Hawaii, who shall be accorded the privilege of the floor with a vote. This representative shall be a member of a component medical society and the Association.

GLADYS C. FRYER, M.D.

Chairman

Special Program Arrangements

The impetus for the formation of this Committee came out of our very, very successful "Fun Night in Hawaii" established for the AMA Interim Meeting held in Honolulu in December 1979, at the Empress Restaurant. Many kudos to the staff for having completed such a successful program.

The backbone of this Committee will again be the staff of HMA working with the chairman. Physician participation will be called upon as needed in the future.

We encourage members who know of any large medical organizations that are in Hawaii or plan to come to Hawaii, that need help in the preparation of a dinner or dinner and show package, to contact the HMA office.

HERBERT Y. H. CHINN, M.D.

Chairman

Editor, Hawaii Medical Journal

ACTION: Approved with the recommendation that the publication of the HAWAII MEDICAL JOURNAL be re-evaluated during the coming year.

Reduced advertising revenues in 1979 compelled us to reduce the size of the Journal from 32 pages to 24, with a resultant savings in cost that will reduce the net deficit for 1980 to a relatively modest sum.

In addition to this, we have engaged a mainland advertising representative, United Media Associates, of Greenwich, Connecticut, in order to beef up our roster of mainland advertisers. Their activity will of course not be able to help our income for 1980, but the prospects for 1981, in the opinion of our realistic, even somewhat pessimistic Executive Editor, Paul Steward, are rosy; we will almost certainly break even, and there is a good chance of turning at least a modest profit on the operation of the Journal.

Associate Editor John Corboy has turned in what is to my mind a completely admirable performance in the writing of editorials; he's a worthy successor to Fred Reppun, which is high praise.

Assistant Editor Doris Jasinski has continued to handle the processing of manuscripts and has served as chairman (NOT chairperson) of the Publications Committee as well.

News Editor Henry Yokoyama has continued to produce his popular column, and has no plans for retirement.

We are still able to publish at least two articles in each issue, and next year may be able to manage three; manuscripts continue to come in at about this rate and we have found nearly all of them acceptable.

We believe the HAWAII MEDICAL JOURNAL is still a great credit to our Society; not many small states have been able to keep their journals going. We feel strongly that it would be a step backward to abandon it, in view of the high probability that it will cost us little or nothing, and may even bring in a profit, starting next year.

We recommend that you authorize its continued publication during 1981 on the same basis as in the past.

HARRY L. ARNOLD, JR., M.D.

Editor

Emergency Medical Services (EMS)

ACTION: Approved as amended, with recognition of Dr. Stanley Saiki for his commendable job as EMS Chairman, as well as the outstanding support given by Senator Patricia Saiki.

1. Background of Hawaii's Comprehensive EMS Law (Act 148)

The law governing Emergency Medical Services (EMS) in Hawaii took effect on July 1, 1979. This law, Act 148, Session Laws of Hawaii 1978, not only established a State Comprehensive Emergency Medical Services System but also gave

legal force and enablement that the Hawaii State Department of Health (SDOH) as lead executive state agency, could contract with the Hawaii Medical Association to perform certain EMS system related professional, technical, and training services.

II. Contract Negotiations for Fiscal Year 1980

Contract negotiations regarding the scope of activities of the HMA-EMS Program proceeded throughout the entire fiscal year (7/1/79-6/30/80). Attempts were made to make the Fiscal Year 1980 contract document a "model" for future contracts by and between the State Department of Health and HMA for its EMS Program. Funding, during the first three fiscal quarters of 1980 was received generally with greater expediency and regularity than for Fiscal Year 1979.

The contract document covering 1980 (7/1/79-6/30/80) was received by the HMA on July 1, 1980 and thereafter resubmitted to the State Department of Health, after being signed by pertinent HMA Officials, on July 17, 1980.

As of August 1980, a final payment for Fiscal Year 1980 services rendered had not been received due to the denial by the Department of Accounting and General Services (DAGS) of the SDOH requested "sole source provider" status being accorded to the HMA for its EMS Program. (A "sole source provider" is, generally, a potential contractor whose services are exclusive of competition and essential.)

A similar SDOH "sole source provider" request covering HMA-EMS services to be rendered during Fiscal Year 1981 (7/1/80-6/30/81) was similarly denied by DAGS. Thus, the HMA found itself to be in arrears for fiscal obligations as of early August 1980, by approximately \$100,000.00. Final payment for Fiscal Year 1980 was received by the HMA on August 11, 1980 after a reconsideration and approval of the sole source by DAGS.

The contract provided the HMA with \$521,321.85 for the period July 1, 1979-June 30, 1980. The provisions of the contract included the following:

- Train and retrain ambulance personnel (emergency medical technicians for Oahu and Mobile Intensive Care Technicians [paramedics] from the entire State).
- Conduct continuing education of emergency services physicians.
- Provide continuing education of emergency, intensive care and critical care nurses (Statewide).
- Provide training and retraining of public safety first responders; firefighters, police officers, and ocean lifeguards for the Island of Oahu.
- Accomplish Statewide data collection and analysis of emergency medical care delivery.
- Provide Statewide evaluation of emergency medical services.
- Conduct research and develop information on techniques for handling disasters and poisonings.
- Disseminate information to the public to enable rapid and knowledgeable use of the emergency medical services system.
- Prepare and draft a grant application for federal funds to develop a basic life support system of EMS on the counties of Maui, Kauai, and Hawaii.
- Provide assistance to the State Department of Health by contracting a communications consultant for the period April-June 1980 to oversee the installation of the Kauai 911 and Central Dispatch System.
- Perform Statewide categorization of acute care medical facilities.
- Assist the State Medical Control Officer in the performance of his duties and functions of medical control.
- Conduct EMT National Registry examinations throughout the State of Hawaii.

The Department of Health additionally requested that the program perform the following function:

- Monitor Neighbor Island EMT and Public Safety training programs conducted by the Community College System on the Neighbor Islands.

During Fiscal Year 1980, a total of \$31,887.83 was spent by the HMA-EMS Program under the State contract for public information and education activities. The most significant tasks performed with these funds for the fiscal year were

as follows:

1. Brochure prepared on MICTs: *HAWAII'S LIFE-SAVING PARAMEDICS* was developed and circulated throughout the State of Hawaii.
2. Production and airing of the following TV public service announcements: "POISONING," "ACCIDENT PREVENTION," "MOVE TO SAVE A LIFE," and "USE EMS WISELY."
3. News releases sent to the Honolulu Star Bulletin, Honolulu Advertiser, the Pacific Business News, Hawaii Hochi, Sun Press, Waikiki Beach Press, Hawaii Tourist News, Hawaii Visitor, as well as to other newsletters and papers of local private agencies including Bank of Hawaii Newsletter, Hawaiian Telephone's "Exchange," etc.
4. Christmas/New Years Holiday campaign included a 10-second TV public service announcement on "Drive Safely, Act Sanely," print media campaign, and radio public service announcements.
5. HMA-EMS assisted the Honolulu County Medical Society in distributing 4,000 copies of its 2-seat belt brochures, posters and bumper stickers to the State Library System—statewide, and the Satellite City Halls in Honolulu.
6. Participation on KITV's public affairs program "Word for Word" December 9, 1979 on "Medical Emergencies" occurring during the holiday season, and December 16, 1979 on "Stress-related Emergencies" occurring during the holidays.
7. Brochure prepared and distributed detailing the training of Oahu's more than 800 field firefighters as Emergency Medical Care First Responders, the Oahu "Co-Response" procedure, and emergency medical services system access.
8. Consultation on public and press relations was provided to the Hawaii Poison Center on their March 1980 Poison Prevention Campaign.
9. Participation on KGMB-TV Community Affairs program "Perspective" to discuss firefighter first responder training, Oahu's co-response system, CPR training of the general public by the Fire Department personnel, and coin-free dialing in public paybooths of emergency services.
10. The program received a "Certificate of Meritorious Community Service" for its work with Hawaii's International Year of the Child Program.
11. United Press International and local press contacted the program on pending State legislation relating to EMS.
12. Grant request drafted pertinent to the conduct of a demonstration public information and education campaign on beach and water safety.
13. Program consultation was provided, at the Hawaiian Telephone Company's request, on the company's public information campaign associated with the conversion of all paybooths statewide to coinless operation for certain emergency and other service numbers.

An in-depth final report covering the activities of the HMA-EMS Program under this contract with the State Department of Health for Fiscal Year 1980 will be submitted to the State by October 1, 1980. Copies for review by interested members of the Hawaii Medical Association will be available from both the HMA Central Office as well as the HMA-EMS Program Office. This report will include numbers trained and retrained in each of the training programs, evaluation and research reports, publications to date, specifics on public information education activities, hospital categorization findings, etc.

III. Status Summary of HMA-EMS Executive Board Meetings for the Period July 1, 1979-July 30, 1980

The HMA-EMS Executive Board met the fourth Tuesday of each month until February when the monthly meetings were changed to the fourth Monday of each month. The Board discussed major programmatic activities and provided overall policy direction to the program. The members of the Board were as follows: five voting members (three members representing the Hawaii Medical Association; one member

representing the State Department of Health; and one member representing the Hawaii Hospital Association). In addition, there were several non-voting members in attendance at the meetings. The HMA-EMS Executive Board reported directly to the Hawaii Medical Association's Council. Pertinent agenda items discussed over the past fiscal year included:

- Review of Revised EMT Training Program
- HMA-EMS Funding for Fiscal Year 1980
- HMA-EMS combined BCLS/ACLS Recertification Pilot Exam
- MAST Garment Usage
- Revisions for MICT Selection Criteria
- Followup on EMT I.V. Venipunctures (legal opinion)
- Report on Contract Negotiations Between State Department of Health and the Hawaii Medical Association for EMS
- Private Ambulance Companies' Communication System
- EMS TV Public Service Announcements
- Board Approval on Pre-Selection Screening Process for all Future EMT Classes
- Grant Request to the Department of Health and Human Services for Neighbor Islands
- HMA-EMS Training Statistics for Fiscal Years 1979 and 1980
- Medical Control Reports
- Selection of Public Relations Firm for HMA-EMS
- Addendum to MICT Selection Criteria
- Update on Legislation
- Review and Discussion of Community College Training Activities on the Neighbor Islands
- Report from MICT Drug Subcommittee
- Staffing Pattern of MICT Training Units
- Oahu Vertical Categorization Findings
- EMS Evaluatory Studies for Fiscal Year 1980
- HMA-EMS Program Budget, Training Schedules, and Training Projections for Fiscal Year 1981
- MAST SUIT Study Report
- MAST MEDEVAC Report
- Approval of HMA-EMS Physician Consultants for Fiscal Year 1981
- Recommendation on Degree of Involvement of HMA-EMS in Statewide Training
- Department of Health and Human Services Notice of Grant Award to the State Department of Health and Conditions Attached to Award

IV. *HMA-EMS Program's Schedule of Activities to be Accomplished During Fiscal Year 1981 (July 1, 1980-June 30, 1981)*

State Funds

On June 3, 1980, the HMA-EMS Program submitted to the State Department of Health a recalculated EMS budget (based on the decrease, by the Legislature, to the request for EMS training funds) for Fiscal Year 1980. The amount required to operate the HMA-EMS Program at its current level is \$623,225.08 from State funds for the 1981 fiscal year.

Federal Funds

The State Department of Health requested in its federal grant application to the Department of Health and Human Services a total of \$437,800.00. Of this amount, approximately \$218,450.00 was requested to be subcontracted to the HMA by the SDOH. This sum of \$218,450.00 (upon its subcontract to HMA-EMS) will be used for the following services: Hiring of an Administrative Assistant; travel for the HMA-EMS Physician Consultants for critical care patient categories; contract with the Hawaii Academy of Pediatrics to develop standards for the care of emergency pediatric patients; development of a curriculum for training trauma nurses; contract with the Community Colleges for the conduct of EMT and First Responder training on Kauai, Hawaii, and Maui counties; performance of a telephone survey on the Neighbor Islands to determine knowledge and attitudes of the general public on EMS.

V. *Status on Funding to the HMA-EMS Program (For Fiscal Year 1981) as of August 1980*

On August 31, 1980, Dr. Douglas Bell, President of the

Hawaii Medical Association, wrote to Mr. George Yuen, Director of the State Department of Health, requesting his personal attention to the following:

1. An advancement to the program for the months of July, August, and September 1980; and
2. Execution of a contract between the State Department of Health and the Hawaii Medical Association for its EMS Program for Fiscal Year 1981 (to include the scope of services and budget for both State and Federal funds).

Presently, the Hawaii Medical Association is awaiting response to its August 11, 1980 letter to Mr. Yuen.

It is anticipated that once the rules and regulations governing the State EMS System have been promulgated, and the contract form executed, that there will be no further problems in this area.

Budget Request for Fiscal Year 1982

MICT Graduations	\$ 600.00/year
Legal Fees	6,000.00
	<hr/>
	\$6,600.00

STANLEY M. SAIKI, M.D.
Chairman

ADDITIONAL REFERENCES

Chinn HYK: Emergency Medical Services—Hawaii. *Hawaii Medical Journal* 32:240, 1973.

Chinn, HYK: Emergency Medical Services Program. *Hawaii Medical Journal* 33:477-479, 1974.

Sims JK, Wright LM, Gavn JA, et al: The Emergency Medical Services Program of Hawaii—I. General Overview. *Hawaii Medical Journal* 35:49-51, 1976.

Sims JK, Akina S, Dods V, Wong LMF: The Emergency Medical Services Program of Hawaii. Part II. Emergency Medical Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel. *Hawaii Medical Journal* 35:227-232, 1976.

Dang W: Emergency Medical Services: *Hawaii Medical Journal* 34:439, 1975.

Sia CCJ: The Oahu Emergency Medical Services Program. *Hawaii Medical Journal* 35:403-405, 1976.

Wong LMF: Emergency Medical Services. *Hawaii Medical Journal* 36:404-407, 1977.

Sims JK, Dang WWL: Five Year Emergency Medical Services Training Update for January 1, 1972-January 1, 1977 and Emergency Personnel Continuing Medical Education Update Effective July 1, 1977. *Hawaii Medical Journal* 37:171-173, 1978.

Sims JK, Pozzi R, Wong LMF, et al: The Emergency Medical Services Program of Hawaii, Part III. The Hawaii Medical Association's Training of Mobile Intensive Care Technicians (MICTs) As Pre-Hospital Paramedics. *Hawaii Medical Journal* 37:203-208, 1978.

Wong LMF: Emergency Medical Services (EMS). *Hawaii Medical Journal* 37:394-395, 1978.

Wong LMF: Emergency Medical Services (EMS). *Hawaii Medical Journal* 38: 389-390, 1979.

Executive Director

ACTION: Approved with commendation of the Executive Director for the excellent job done.

As reported in almost every year's report, the pace of activity, the amount of involvement, by your Association has rapidly increased. Legislatively, financially, medically, and other aspects of the Association have taken some very great leaps. The entire matter of what your Association has done, however, boils down to your Association undertaking some very heavy activities and responsibilities with a reduced amount of resources due to the steady drop in dues-paying membership. And yet, in all of our activities, especially in our interface with the state legislature, the Hawaii Medical Association is looked to for an expression of the medical profession in Hawaii. No other physician group can represent so many different kinds of physicians. If HMA were to dissolve tomorrow, our community would look for another physician's group to speak on behalf of the medical profession. Our financial picture looks grim at this point (but not fatal) because of the decreasing number of dues-paying members, and in spite of this situation, your HMA leadership has accomplished much during the past year.

I must, this year, especially let you members know how much I appreciate your staff, for we are understaffed; yet, the pace of activities and the work accomplished keeps growing. It is generally accepted that service organizations have

65% of their budgets tied up in personnel costs. The HMA personnel costs reflect less than 44% of the applicable budgets, and this is after one removes all of the federal and state project costs from the budgets. I certainly appreciate each and every one of your staff; I hope you do, too.

What the HMA has specifically accomplished is presented in other reports and I need not duplicate their presentation, but the commitment and dedication of the HMA members needs to be recognized, for, without such commitment and dedication, there would be no Association. The theme I wish to present in this report is that, because the HMA is a voluntary membership association, there is no penalty for not belonging, and while HMA is moving in directions that will bring, hopefully, economic-type benefits to members, the basic motivation should be professional responsibility and obligation. When your HMA spends 200 hours fighting the state health authority bill in the state Legislature, it is not fighting only for its members; it fights for *all* physicians. When your HMA spends 300 hours lobbying for increases in Medicaid payments to physicians (in the House, there were no increases proposed in the budget), it fights for increases that benefit *all* physicians, not just HMA members. During these two issues, I saw not one non-HMA member helping to benefit patients. If no physician paid any dues, there would be no Association, and if there were no Association, I do not believe that the state health authority bill would have been defeated (it passed the State Senate) nor would there have been any increases in physician reimbursement under Medicaid. Do non-HMA members not accept the increases in Medicaid reimbursement? Do they voluntarily comply with the onerous provisions of the state health authority bill? I doubt it; yet only 55% of the physicians in this State belong. They may feel that there is no sense in joining because they get the same benefits when HMA challenges or promotes legislation. There are other examples of what your dues have done to assure physicians that *someone*—physician members and staff—will be *available and knowledgeable when needed*. You members have provided the professional and financial support to your Association that does this for you, but what about your colleagues that do not provide such support and reap these important benefits? Do they not deserve to have such issues brought to them by you members? I believe it incumbent upon each HMA member to get into membership recruitment and retention. If each one of the 55% of the medical profession that now belongs recruited *one* new member, your HMA would really be able to represent the medical profession in Hawaii. But it takes a commitment and a real sense of responsibility to see that this gets done.

The 1980 Leadership Conference will, hopefully, allow your Association to utilize a system of prioritizing activities and for funding of such activities within the Association's resources on a realistic basis. This system is a "must" in light of decreasing dues income. As the number of dues-paying members decrease over time, and as the cost of goods and services and of doing business increases, your Association will have to reduce the services and activities it undertakes or is undertaking on your behalf unless the trend of decreasing dues-paying members is reversed soon, and significantly. It also appears that the Leadership Conference is looking toward developing alternative sources of revenue for the Association so that increases in dues in the future can be moderated.

I can only express grateful appreciation to the dedicated HMA leadership and to the physicians who are members of the HMA, for their support during the past year in the face of mounting problems demonstrates one of the highest forms of professional responsibility in my opinion.

Recommendations:

- 1) That the House of Delegates support the recommendations of the Leadership Committee Report;
- 2) That each member of the HMA recruit *one* new member during 1981;
- 3) That each HMA member volunteer for at least one committee/commission assignment during 1981.

JONATHAN R. WON
Executive Director

Legal Counsel

ACTION: Approved with commendation of Mr. Tom Rice for the long and dedicated service he devotes to the Association.

This report covers the approximate 12-month period from September 5, 1979 through September 12, 1980.

During this period, your legal counsel attended the sessions of the House of Delegates and the Reference Committees, and attended most of the Hawaii Medical Association Council meetings. In addition to services to Hawaii Medical Association and Honolulu County Medical Society, services were also rendered to Physicians Exchange and the EMS Program.

Subjects on which we conferred with the officers and other authorized personnel of Hawaii Medical Association and Honolulu County Medical Society related to: An extensive analysis, after research, of a request that physicians consider issuing prescriptions for narcotics to non-patients for the purpose of creating evidence of errors or omissions by pharmacists in processing those prescriptions (we concluded that they should not); the obligation of a consultant physician to report his findings and conclusions to the patient as distinguished from the referring physician, and the efficacy of a patient's authorization to release information; the annual audit of Hawaii Medical Association; the Relative Value Study and the wisdom of adoption and publication of the same; several inquiries relating to problems from the Legislative Committee, including comments relating to the new physician-patient privilege statute (counsel does not like it); a follow-up inquiry relating to Peer Review by specialty societies; further work on a review of the retention of medical records which project is not completed; several follow-up inquiries on consideration of intervention in pending litigation relating to the right of a doctor to deny access to patient records by DSSH personnel (a further U.S. District Court decision is expected shortly); responding to an inquiry relating to the doctor's position where patients claim for reimbursement from more than one insurance carrier; an inquiry on subdividing a county to create dual semi-county medical societies; several conferences relating to change in Pension Plan Actuaries and actuarial assumptions; the HEPA suit vs. DSSH; the Bylaws of Honolulu County Medical Society and of the Association; a fraud investigation against an Association member; the yellow page identification of HCMS members; the responsibility of a physician for opining that a person is capable of operating a motor vehicle; the procedures of splitting PSRO from HMA administrative operations; the role of a subpoenaed physician as an expert witness; general administrative questions relating to the operation of 320 Ward Avenue Building; and review of an apparent fraud in billings to Hawaii Medical Service Association.

Your counsel concluded a conciliation settlement of the complaint by the Federal Election Commission against the Association; reviewed the EMS contractual relationship; conferred without charge to the Association with the members of the ENT Society relating to their organization; conferred with the Maui County Medical Society without charge at a meeting relating to their incorporation; attended a meeting of the Association of Medical Society Attorneys at the Association's expense for travel and per diem, and at your counsel's expense for his time. This was valuable for the Association since their problems are our problems. Your counsel combined that meeting with an AMPAC Conference.

Your legal counsel has no recommendations and no budget request.

V. THOMAS RICE
Legal Counsel

President

ACTION: Approved.

As I look back over my year as HMA President, I see it as a typical "Good News-Bad News" year but never has it been a dull or uninteresting year. I thank everyone connected with HMA from the staff through the membership for their support and help. It has been one of the most memorable and

rewarding years of my life and I am pleased to have had the opportunity to experience it. Whether anything of lasting value has been accomplished will take time to discover, but I can certainly recommend the HMA to anyone; it is a worthwhile, vibrant organization.

The working highlight of the year were the months spent in the legislative effort. It was long and involved, but I think some headway was made in trying to forge a closer personal relationship with many of the legislators. The updating of the DSSH Medicaid fees to 1979 profiles this year required working with several committees in both the House and Senate and presenting our views vigorously yet fairly. As all MD's know, this was the first updating of fee profiles in several years but to continue this momentum will take a strong effort annually by the HMA and our physicians. It will not be easy.

By working with the two specialty societies of Ophthalmology and Orthopedics, this year we were able to contain the thrust of the optometrists, chiropractors and chiropractors, who want to be allowed more practice privileges. Should those groups be successful, this would be a glaring example of the granting of licensure for the practice of medicine by legislation without regard to training. This problem demonstrates the parallel common needs of HMA and the specialty societies which needs to be fostered. Also, these efforts of non-physicians to gain licensure to practice medicine will not disappear and will necessitate continued hard work by our organizations to combat each year.

The creation of the DSSH Drug Formulary and the Generic Drug Bill are examples of the "Bad News" this year while the Health Authority bill which came too close to passage for comfort demonstrated the sentiment of some powers who want to control our practice and thus our means of livelihood. Again, this shows how much work lies ahead for us.

Though I think most of us agree that the Emergency Medical Service improves medical care in our state, it is not an unmixed blessing. The program to train various emergency paramedical personnel as you know is supposed to be funded by a direct grant to HMA from the Legislature through the Department of Health. However, our staff spent much unnecessary time and energy negotiating with the Department of Health to obtain our rightful funds to run the program and even now we have not been able to get a signed contract for the time since July 1 and the grant for 1979-80 was only finally signed in August 1980. During these times, we have had to advance HMA's personal funds to run the program while we waited for the contract. Our own monies were supposed to be used for our other programs which thus had to be curtailed. We have tried unsuccessfully to get a penalty clause inserted in the contract to force the DOH to meet its obligations promptly. We should scrutinize our involvement in this program closely.

In another area of government activity, the State Health Planning and Development Agency (SHPDA) continued to flex its muscle by insisting on certificate of need (CON) requirements for many things such as new facilities costing over \$150,000, CT scanners, hospital charges, etc. It is ironic that several agencies of government now agree that CT scanners are indeed a major advancement in medical care and not an expensive medical toy as they originally insisted. I understand from knowledgeable radiologists that the worst aspect of the SHPDA blockages in this area is that the companies who were developing this new technology now are reducing their efforts in research to improve scanners because they fear what the future from the regulation standpoint holds. Again, I don't think that SHPDA will disappear and it will keep us health providers on the defensive for a long time to come.

The Federal Trade Commission's ruling on RVS schedules and the various national suits and possible counter-suits have kept HMA on edge and divided our ranks on what to do in this area. I think we are a small organization with limited resources and must behave accordingly. I also note that some of the MD's pushing us hardest to fight in court are not HMA members and thus have little to lose. We should encourage other agencies such as the Worker's Compensation

Division to develop these schedules and try to get our input incorporated that way.

The malpractice insurance scene is still active despite Argonaut Insurance Company reducing their rates a little and HAPI becoming operative. I earlier reported that the Ad Hoc Malpractice Insurance Crisis Committee had raised more than \$10,000 and had hired an attorney to petition the state insurance commissioner to hold a hearing to evaluate malpractice insurance rates. This is the current status and future actions are now up to HMA, the Crisis Committee, and the Insurance Commissioner. Other possible pending "good news" is that Medical Insurance Exchange of California (MIEC) has applied to sell malpractice coverage in Hawaii, and could be operating by this coming January. MIEC is a malpractice insurance company owned and operated by the Alameda and Contra Costa Medical Societies, and it has recently expanded to Idaho and Alaska. It appears to be a sound, successful company. HMA must continue to encourage all these ideas which could well help to bring lower and more competitive insurance rates here. Good peer review activities by our committees will help immeasurably in these efforts as well.

In this vein, during this year fledgling efforts to work with impaired physicians, at least on the county level, and interest in poor controlled substances prescribing practices of some physicians have surfaced and should continue.

The problems of PSRO continue and their budget has shrunk again during this last year. The HMA Council heard twice during the year from Pacific PSRO President Dr. Winfred Lee, and his main message seemed to be the precarious condition of PacPSRO and the possibility it may be defunded by March 1981. He pointed out, however, that that does not mean that the program will disappear for its duties probably will be assumed by some other PSRO or other governmental organization.

Cancer programs have not been as much a part of HMA discussions this year, but the Council did agree to HMA developing a handbook of guidelines for diagnosis and treatment of some of the commoner cancers, under contract with the Community Cancer Program of Hawaii (CCPH). This handbook will be widely disseminated to physicians and others involved in cancer work. It will be only designed as guidelines for handling various types of cancer and not as standards of therapy.

Discussions and studies of health manpower, especially in reference to physicians and nurses were carried out during the year and a study on physician manpower was published by SHPDA. This study showed a very abundant and probably an oversupply of almost all types of physicians within the next five years. This study should be evaluated more fully by HMA and courses of action on its recommendations undertaken. The UH Medical School has many good points, but it could easily oversupply Hawaii with physicians if it continues on its present course.

It appears our building is on a stable, profitable course; but it has been difficult for the Building Committee to meet this year partly because of difficulty assembling the neighbor island representatives. When it does meet an hour before Council meetings, the committee doesn't have time enough to consider the complex financial issues of building ownership. Maybe a better method of administering the building would be an elected, standing building management committee.

The two-day HMA Leadership Conference was a great success and involved about 75 members looking at HMA's future goals. It was held at the Ilikai Hotel in August. It developed four missions for HMA with ideas for future strategies to accomplish them. This document has been presented to this House of Delegates for debate and action. It deserves careful consideration of all our members for it is the long-range plan of HMA.

Another successful ongoing project both from its own intrinsic value and as good public relations for the Association is the Jail Health Project funded by the Law Enforcement Assistance Agency through the AMA. This project should continue with AMA support for several years.

There were two totally fun activities that HMA was in-

involved in during the year. One was the four-day visit of the leaders of the Hiroshima Medical Association to Hawaii January 1-5, 1980, and the other the sponsorship of "Fun Night in Hawaii" developed by Dr. Herbert Chinn during the Interim Meeting of the AMA House of Delegates here in Honolulu in December 1979. These will be long remembered by those who participated.

In a more general and serious note, the major problem for HMA as I see it is the declining percentage of membership among Hawaii physicians in our Association. This cuts our manpower and financial resources as well as threatens our image as a spokesman for Hawaii's medical community. This decline has continued despite active recruiting drives and recruitment incentives for members. I am impressed daily that organized medicine serves an important function for all physicians that cannot be met by other organizations such as specialty societies, but many physicians either ridicule the operation or are indifferent to its existence. To protect the organization, I think as so many of you that we must find ways to limit the present benefits to only the members or to find other benefits for members. It is amazing how much more important hospital membership and activities are to many physicians.

Another problem looming on the horizon for HMA is the HMO movement. Thus far AMA and HMA are committed to a pluralistic system of health care delivery so that each recipient can pick out the system that suits him or her best whether it is an HMO such as Kaiser, fee-for-service such as HMSA, or other system. The major issue AMA has taken against HMO's is the large government financial incentives offered at present to that form of health care.

At least one meeting was held in Honolulu recently with various physicians concerning this issue and I foresee much more action there in the future. I also am opposed strongly to the government incentives offered to these programs and I wonder if HMSA should be allowed to run one of its own as it seems like a strong conflict of interest to me.

Again thank you, one and all, for your support during this year. My special thanks go to the staff, the officers, the Council, the commissioners and the committee chairpersons who devoted so much to the organization. I couldn't have done it without you.

Recommendations:

- 1) To improve membership and involvement in areas like Kona and other areas of counties far from the seat of the county medical society where membership is especially poor; serious consideration should be given to encouraging the formation of formal medical association districts or other units either as part of the county medical society or with direct representation and/or input into HMA.
- 2) To improve management of the HMA building, a staggered term, elected Building Management Committee with membership from those especially interested and expert in this area and meeting on a more regular basis should be considered. Neighbor island interests could be protected by designating certain member(s) of the committee from there. The HMA President and Treasurer should also be members.

DOUGLAS B. BELL, II, M.D.
President

Secretary

ACTION: Approved. The minutes of the Council meetings were ratified as circulated.

The total membership of the Association as of December 31, 1979 was 925, an increase of 22 as compared to December 31, 1978, when membership totaled 903.

Eight members died since the last meeting: Drs. Walter Chung, Mor J. McCarthy, Carl Johnsen, Perry Sumida, Lyle G. Phillips, Fred L. Giles, P. S. Irwin, and Tadao Hata.

By counties, as of December 31, 1979, the active membership was made up as follows:

County	Active Dues Paying	Active Dues Waived	Special	Total
Honolulu	589	137	35	761
Hawaii	49	13	2	64
Maui	63	12	—	75
Kanai	18	7	—	25
TOTAL	719	169	37	925

As of August 31, the membership has decreased to a total of 911, with 693 Active Dues Paying, 174 Active Dues Waived, and 44 Special.

A pilot membership incentive program was launched this year in cooperation with the HCMS and the AMA. Established members who have recruited a new member into the Association will receive a dues credit of \$100 on next year's dues. Under this incentive pilot program, HMA has gained 11 new members. Hopefully, we will continue to recruit new members actively, as well as to retain our current members.

Since the last meeting, the Council met on the following dates: November 2, 1979, December 7, 1979, January 11, 1980, March 7, 1980, April 11, 1980, May 2, 1980, June 6, 1980, July 11, 1980, and September 5, 1980. Copies of the minutes of these meetings are attached for ratification by the House.

K. Y. LUM, M.D.,
Secretary

Treasurer and Finance Committee

ACTION: Approved as amended, with the recommendation that for recommendation no. 3, a survey be conducted to determine the appropriateness of the annual payment amount by HCMS.

This report is a combined report since your Treasurer also serves as the Chairman of your Finance Committee. Your Treasurer has assured that the financial statements during the year were an accurate reflection of the financial condition of your Association. Last year, the budget of the HMA demonstrated the weaning off of the HMA of federal dollars, i.e., reflecting federal monies via grants and contracts in the HMA budget. For 1981, your Finance Committee, in its quest to have the HMA stand alone, has virtually prepared the proposed 1981 budget based on HMA resources alone; and the results are sobering. If the HMA is to provide for its programs, activities, and operations from its own resources, then its budget should reflect just that. Your Finance Committee also felt strongly that HMA should continue to support federal and other outside-support programs and activities as long as they are not financially detrimental to the HMA.

For 1981, your Treasurer and Finance Committee have taken some long, hard looks at the financial resources and condition of your Association. We find that our reserves, at present, are much lower than ever, due mainly to the HMA "front-ending" the purchase of its computer system but which we expect to recover on a lease/purchase option already arranged for, and due to the "paying for/reimbursement" mechanism for some of our activities, such as PSRO, EMS, and the Tumor Registry. This area will have to be watched very closely during the next year as this provision of monies causes lost interest earnings based on the time value of money. The deficit budgets adopted by previous House of Delegates must cease, or your Association will suffer the inevitable consequences. The most important measure of your Association's ability to live within its resources boils down to the number of dues-paying members. This number has been steadily increasing each year until 1976, when the HMA experienced its first drop in dues-paying members. It has steadily declined over the past five years to a point where it is at its lowest level since 1969. In order to continue where we are, even with belt-tightening which has been cranked into the 1981 proposed budget, your Finance Committee is recommending a dues increase of 10% (\$27 per member).

Only with such an increase, can your HMA cope with the decreasing number of dues-paying members and the increasing costs of doing business.

Recommendations:

- 1) That the dues for 1981 be \$297 per member.
- 2) That the entire Association be included in a membership retention/recruitment program.
- 3) That a contract for services to be provided in 1981 to the Honolulu County Medical Society be adopted for an annual payment of \$89,325, subject to negotiation and approval by Council.
- 4) That this budget be adopted as amended.
- 5) That the auditors for the HMA be Alexander Grant & Company.

WILLIAM H. HINDLE, M.D.,
Treasurer

Capital Fund Advance Plan

The Capital Fund Advance Plan (CFAP) was created in 1975 by the HMA House of Delegates to provide the necessary funding for a "home" for the HMA and its related organizations and activities. It was by pure coincidence that almost at the time of inception, the HMA was presented with an excellent opportunity to purchase its new "home." Thus, the present HMA Building at 320 Ward Avenue, Honolulu, Hawaii, was purchased on an Agreement of Sale for 10 years.

The Capital Fund Advance Plan was debated long and hard during the meeting of the delegates. The basic disagreement was over whether the monies for the CFAP should be obtained as part of the dues of HMA (thereby making it deductible to the physicians), or whether or not monies should be obtained via a mandatory loan on behalf HMA members (meaning physicians will eventually have the monies returned to them but cannot deduct any amount off their taxes). The two approaches were split just about 50-50 in the HMA House of Delegates. The mandatory loan approach was finally adopted.

The HMA House allowed three options for the payment of this mandatory, \$1,000 loan to HMA: (1) payment in full with a 10% discount (10% discount would apply to any payment in full over \$100); (2) \$100 per year for ten years; and (3) \$10 per month for a minimum of 10 months per year for 10 years. Our actuaries calculated that of the monies collected under this Plan, 20% should be kept in liquid assets to pay off those physician members who retire, leave the islands, etc., and the rest could be used to assist in our mortgage payments.

Needless to say, this Plan has accomplished what it was intended to do. A copy of the Balance Sheet as of June 30, 1980 is presented.

Basically, what the Balance Sheet demonstrates is that the Plan has collected a total of \$317,667 since the Plan's inception. To date, the Plan has cash reserves of \$81,157, well in excess of the 20% of monies collected (\$63,534) required in liquid assets. Based on our current membership figures, an additional \$406,333 is still owing under the Plan by HMA members. For this year alone (1980), the first six months have also generated \$3,287 in interest.

It is the hope of the Finance Committee that current efforts in finding a suitable program to re-finance our current Agreement of Sale will be successful and that loans made to date can begin to be returned to the membership.

JONATHAN R. WON,
Executive Director
FOR HMA FINANCE COMMITTEE

Resolution No. 5

ACTION: Not Adopted.

Re: Unity Membership Rule

WHEREAS, in prior years there has been a high proportion of the HMA membership who feel the UNITY MEMBERSHIP RULE impairs our ability to recruit physicians into the Hawaii Medical Association, and

WHEREAS, the high cost of membership in the State and County Medical Societies plus the AMA dues presents an economic hardship for many physicians that they are unable or unwilling, to meet, and

WHEREAS, our dependence upon AMA for leadership in the many faceted programs that affect our profession nationally, and especially their leadership and "watch-dogging" the vast number of legislative proposals in the Congress of the United States continues unabated with even greater need for additional members and the higher percentage of membership of physicians nationally, but not withstanding the author of this resolution feels that the greatest threat to the free enterprise practice of medicine over the next five years lies on the local scene with the State Legislature and where the current membership of HMA can speak for only slightly over half of the physicians of the State, and

Hawaii Medical Association
1981 Budget

INCOME:	Estimated 1980	Budget 1980	1981 Budget
Dues	\$190,000	\$206,900	\$220,000
Journal	45,000	52,000	48,000
Annual Meeting	35,000	18,000	26,000
CME	1,300	1,000	500
Fee Survey	300	-0-	-0-
Roster	200	1,500	2,500
Contract Services-HCMS	86,100	86,100	89,325
Dues Collection Service	1,700	1,700	1,700
EMS Accounting Service	5,000	1,250	12,000
Indirect Cost-EMS (state)	-0-	-0-	-0-
Indirect Cost-TR	43,000	-0-	-0-
Interest Earned	6,000	16,000	14,000
Miscellaneous	150	100	100
Other Reimbursed Revenues	1,000	4,500	54,500
Payroll Tax Reimbursement	47,000	47,000	42,000
PSRO Salary Reimbursement	200,000	201,650	-0-
PSRO Services Reimbursement	30,000	44,000	-0-
PSRO Meeting Expense	5,000	7,000	-0-
Printing/Xerox	5,000	4,500	5,500
Retirement Reimbursement	120,000	131,000	100,000
Travel Reimbursement	2,000	-0-	2,000
TOTAL	\$823,750	\$824,200	\$618,125

WHEREAS, we need the support of a much higher membership of our physicians statewide to support the coming progressive struggles with our State Legislature, therefore, be it

Resolved, that the Unity Rule be dropped for a trial period of three years, allowing members to be conscripted to join the respective County and Hawaii Medical Association wherein they can be much more exposed to the activities of the AMA and the need for our support of it and that we continue a vigorous effort to retain existing memberships in the AMA and that if we fail to achieve a 25% gain in membership in the HMA by the end of three years, that the unified membership with the AMA would automatically be reinstated. If such 25% increase in State membership is achieved, then the HMA would poll its membership and the House of Delegates in 1983 which would determine whether the unified membership was to be reinstated or not.

E. LEF SIMMONS, M.D.

Community Research Bureau

ACTION: Approved.

This Bureau of the HMA, a scientific, educational, and charitable organization, continues to be an important fiscal

agent for the HMA in handling and processing funds of a charitable, scientific, and educational nature. It handles funds for the HMA-Emergency Medical Services program as well as funds from organizations for health education purposes. Current financial statements are on hand at the HMA offices for inspection by any interested member. Your Community Research Bureau wishes to see additional activity through the organization for the betterment of the public health, and encourages the Association to pursue a course in this direction.

Your Bureau only wishes to recommend that it be continued with its present stated purposes on behalf of the HMA.

O. D. PINKERTON, M.D.
President

Hawaii Foundation for Medical Care

ACTION: Approved.

The Hawaii Foundation for Medical Care has been inactive during 1980, as it has been for a number of years. There has been some thinking that, as the Foundation has not been active, that it should be dissolved as a corporate entity. The Foundation has been kept alive as a possible vehicle through which potential activity determined by the HMA could be

Hawaii Medical Association
1981 Budget

EXPENSES:	Estimated 1980	Budget 1980	1981 Budget
Salaries	\$420,000	\$417,650	\$267,000
Auditing	7,100	6,800	7,000
Auto Expenses	8,800	8,800	5,500
Computer Lease/Maintenance	10,000	19,200	19,200
Computer Reports/Supplies	1,000	1,000	1,000
Council Contingency	600	5,000	-0-
Council Expenses	4,500	4,500	5,000
Donation	700	1,000	1,000
Dues and Subscriptions	750	500	750
Education and Training	500	1,000	-0-
Equipment Purchase	3,500	1,000	400
HAMPAC Education	500	500	500
Insurance and Bond	10,000	10,000	11,000
Interest-Equip. Loan	2,400	2,400	1,500
Lease-Office Equipment	600	3,600	600
Legal	12,000	20,000	12,000
Library Contribution	5,000	5,000	-0-
Meeting Expense	18,000	18,000	10,000
MICT Graduation	600	600	600
Miscellaneous	300	500	-0-
Postage	5,000	4,800	6,000
President's Assistant	-0-	-0-	-0-
President's Contingency Fund	1,500	2,000	1,500
Repairs and Maintenance	5,000	5,000	5,000
Retirement Contribution	117,000	117,000	108,000
Special Authorized Exp.-TR	8,500	10,000	5,000
Special Council Contingency	-0-	40,000	-0-
Stationery, Printing, Supplies	14,000	8,000	20,000
Taxes	63,000	63,000	54,000
Telephone	4,000	4,000	4,000
Travel	11,000	10,000	14,000
Trustee Campaign	2,000	2,000	-0-
Auxiliary	16,600	16,600	14,100
Committee Expenses	16,500	34,200	19,000
Journal	43,000	43,000	44,000
Annual Meeting	34,000	18,000	23,000
Roster	3,700	3,700	-0-
CME	4,500	9,800	400
Fee Survey	-0-	-0-	-0-
	<u>\$856,150</u>	<u>\$918,150</u>	<u>\$661,050</u>
NET GAIN (LOSS)	<u>(\$ 32,400)</u>	<u>(\$ 93,950)</u>	<u>(\$ 42,925)</u>
Note: Add \$43,000 HTR:			+43,000
NET GAIN			<u>\$ 75</u>

accomplished, but no activity has come to fruition during the past year. However, during the past few months, potential programs for the HMA have come to light, and the leadership of the HMA has had some discussions regarding these possible activities. The HMA leadership is, at the time of this report, pursuing the establishment of further meetings regarding future possible activities that could affect the outlook for the Hawaii Foundation, and as such, the Hawaii Foundation should be continued as a subsidiary of the HMA for another year.

WINDRED Y. LEE, M.D.
President

HAMPAC (Hawaii Medical Political Action Committee)
ACTION: Approved as Amended.

HAMPAC (Hawaii Medical Political Action Committee) activities in 1980, an election year, were primarily directed toward increasing membership and providing fund raising support for legislators supportive of the purposes of organized medicine. In the early part of the year, HAMPAC provided support to 25 incumbent legislators and 1 aspiring candidate running for the House of Representatives, Mrs. Connie Chun, wife of Dr. H. H. Chun.

As a bipartisan political action committee, HAMPAC provided campaign support funds to 38 legislative candidates running for election or re-election in the 1980 Primary. Campaign support funds will also be made to legislative candidates before the General Election on November 4, 1980.

At the Board of Directors meeting on August 21, 1980, it was reported that AMPAC was raising their dues to \$20 per individual effective January 1, 1981. It was moved, seconded, and passed by the Board that HAMPAC solicit all physicians in the State with a separate HAMPAC mailing and suggesting a voluntary contribution of \$99 for an individual membership, \$20 of which would go to AMPAC. The individual physician would have the option of designating whether he wanted to be a Sustaining Member in which case \$50 of his contribution would go to AMPAC and HAMPAC would keep the remaining \$49.

The Board considered the idea of sponsoring a joint political action workshop with AMPAC to be held sometime in January 1981 just before the legislative session begins.

HAMPAC membership for 1980 totaled 218 contributors of which there were 10 sustaining members.

Budget Request: In order to carry out the proposed activities for the coming year, the HAMPAC Board of Directors submits a proposed budget in the total of \$500 for the 1981 educational fund.

L. Q. PANG, M.D.
President, HAMPAC

Nominating

ACTION: Approved.

The HMA Nominating Committee met to receive nominations for officers and other elected positions of the Hawaii Medical Association that are to be elected by the HMA House of Delegates at its Annual Meeting on October 13-17, 1980. The Nominating Committee submits to the House of Delegates the following slate of nominees:

- President-Elect Ann B. Catts, M.D.
(1 to be elected, 1-year term) Arch T. Wigle, M.D.*
- Secretary Leonard Howard, M.D.
(1 to be elected, 2-year term) K. Y. Lum, M.D.
- Alternate Delegate to AMA ... William Iaconetti, M.D.
(1 to be elected, 2-year term) Richard O. Lundborg, M.D.
- Councilor from Kauai John Newman, M.D.
(1 to be elected, 2-year term) Mark A. Wentworth, M.D.
- Councilors from Honolulu Nadine C. Bruce, M.D.
(4 to be elected, 2-year term) Thomas G. Cahill, M.D.
Bernard W. D. Fong, M.D.
Doris R. Jasinski, M.D.
Philip I. McNamee, M.D.
Kenneth Pruett, M.D.
E. Lee Simmons, M.D.

*Due to unusual circumstances, Dr. Arch Wigle withdrew his name from nomination to the office of HMA President-elect for 1981.

WILLIAM W. L. DANG, M.D.
Chairman

Election

ACTION: The report of the Nominating Committee was presented, and the President called for nomina-

**Hawaii Medical Association
1981 Budget
Schedule of Committee Expenses**

	Estimated 1980	Budget 1980	1981 Budget
Legislative Committee:			
Lobby/Legal Counsel	\$ 1,000	\$12,000	\$ 1,000
Dinner/Entertainment	- 0 -	- 0 -	2,500
Subtotal	\$ 1,000	\$12,000	\$ 3,500
Public Affairs Committee:			
News Media Award	800	1,100	800
Science Fair	200	200	200
Tel-Med	8,000	6,500	8,000
Dues/Subscriptions; Printing; Postage	- 0 -	8,400	- 0 -
Medical Student Affairs	- 0 -	500	- 0 -
Subtotal	\$ 9,000	\$16,700	\$ 9,000
TV-Radio Committee:			
Video/Production Costs	5,000	5,000	5,200
Public Affairs Committee:			
For 125th Anniversary	- 0 -	- 0 -	1,000
Sports Medicine Seminar	500	500	300
Voluntary Effort	- 0 -	- 0 -	- 0 -
Medical Ethical, Moral & Legal Concerns Committee	1,000	- 0 -	- 0 -
TOTAL	\$16,500	\$34,200	\$19,000

tions from the floor. Dr. Calvin C. M. Kam was nominated to the office of HMA President-elect for 1981. A motion to close the nominations was made, seconded, and passed. Drs. Bernard Fong and Patrick Walsh were appointed tellers, and the ballots were distributed. The following were elected:

President-Elect Ann B. Catts, M.D. (1981)
 Secretary Kwong Yen Lum, M.D. (1982)
 Alternate Delegate to AMA William Iaconetti, M.D. (1982)
 Councilor from Kauai John Newman, M.D. (1982)
 Councilors from Honolulu Nadine C. Bruce, M.D. (1982)
 Thomas G. Cahill, M.D. (1982)
 Bernard W. D. Fong, M.D. (1982)
 E. Lee Simmons, M.D. (1982)

The Nominating Committee was elected as follows: Honolulu—Drs. Douglas Bell, II, William Dang, Henry Fong, James Lumeng, Patrick Walsh; Hawaii—Arch Wigle; Maui—Denis Fu; Kauai—Yonemichi Miyashiro.

New Business

ACTION: The House of Delegates voted to commend Dr. Bell with a standing ovation for his outstanding leadership and dedicated efforts this past year as HMA President.

The meeting adjourned at 5:45 p.m.

KWONG YEN LUM, M.D.
Secretary

Awards

Medical Reporting Awards

Commercial Newspapers and Magazines—Murry Engle (Honolulu Star-Bulletin)
 Television—Linda Coble (KGMB-TV News)
 Institutional Newspapers and Magazines—Christie Adams (Ha'i Mai, Kapiolani Children's Medical Center)
 Non-professional, School Newspaper, and Magazines—Catherine Cross (Castle High School)

A. H. Robins Award—(1980 Physician Award for Community Service)—Robert D. Millard, M.D.

Sportsmen's Awards

Golf:

President's Trophy (Low Net)—Edward K. Kagihara, M.D.
 Robert Miyamoto Perpetual Trophy (Low Net)—Edward K. Kagihara, M.D.
 John Felix Perpetual Trophy (Low Gross)—Michael Okihiro, M.D.
 William Yarbrough, M.D.
 George Mills Perpetual Trophy for Pharmaceutical Representatives (Low Net)—James Asato

Table Tennis:

Singles—Philip McNamee, M.D.
 Doubles—Philip McNamee, M.D. and John Spangler, M.D.

Tennis:

Singles: Open Division—Gerard Dericks, M.D.
 Novice Division—Roland Tam, M.D.
 Over 50 Years Division—Bal Raj Mehta, M.D.
 Doubles: Open Division—Benjamin Chang, M.D. and Gerard Dericks, M.D.
 Novice Division—Ronald Peroff, M.D. and Patrick Walsh, M.D.
 Over 50 Years Division—Leabert Fernandez, M.D. and Yutaka Yoshida, M.D.

as•so•ci•a•tion (e•sō'sē•ā'shen, -shē-) *n.*

1. The act of associating. **2.** The state of being associated; fellowship; companionship. **3.** A body of persons associated for some common purpose; society; league. Abbr. *ass.*, *assn.*, *assoc.*

JOIN US

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HAWAII MEDICAL ASSOCIATION

320 WARD AVENUE, HONOLULU, HAWAII 96814

staff and patients to get into this educational Sunday evening habit. Try it yourself, doc; you'll find this beats most other CME. Get the picture?
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Back Your Pac

Do you want big government, federal or state, to tell you what specialty and where you may establish your practice? To set your fees? What professional equipment you may use?

If your answer is no then every physician in Hawaii must become involved in the political process. Involvement entails either active campaigning or lobbying effort through organized medicine's legislative committees or through organized medical political action committees, commonly referred to as PACs. At the local level we have the Hawaii Medical Political Action Committee (HAMPAC) and the American Medical Political Action Committee (AMPAC) at the national level representing the voice of medicine under the free enterprise system. The physician who says that he or she is above politics is really saying that democracy is beneath them. We recognize that the varying demands of individual practices does not allow all physicians to participate in organized legislative and lobbying efforts in behalf of their profession. However, all physi-

cians, regardless of their affiliation, can contribute meaningful financial campaign support to worthy candidates in the name of organized medicine through their PAC organizations.

HAMPAC and AMPAC are voluntary, non-profit, non-partisan organizations bound neither by Democratic, Republican or other party labels through which physicians, as active citizens in our community can best support legislative and congressional candidates of their choice. *To effectively provide financial support for such candidates the Board of Directors of HAMPAC has approved the suggested annual contribution of \$99 for individual membership. \$20 of this contribution will be forwarded to AMPAC to support medicine's legislative efforts at the national level. The balance will remain with HAMPAC for the support of candidates for election to the Hawaii State Legislature. For physicians who desire to be Sustaining Members of AMPAC, HAMPAC will forward \$50 of their individual membership to AMPAC.*

Since 1972, solicitations for HAMPAC/AMPAC voluntary contributions have been included with County and State annual dues statements. Commencing in 1981 your HAMPAC Board, in its continuing effort to reflect the political interests and support of all physicians in Hawaii, is making direct solicitations to all licensed practicing physicians. \$99 is a sound investment in your future practice of medicine.

Honolulu Orthopedic Supply

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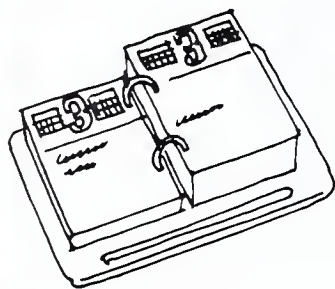
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Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Kamehameha I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

- B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1.
 - A. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 - B. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respcio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.

2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics
6. Tumor Bd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Internal Medicine Dept. Mtg., Second Tuesday, Evening, 6:00-7:00 p.m.
2. Department of Ophthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
3. G. I. Conference, Third Tuesday, 8:00-9:00 a.m.
4. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
5. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
6. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
7. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
8. Surgical Conference, Fifth Friday, 12:45-1:45 p.m.
9. Surgical Mortality & Morbidity Conf., Second and Fourth Friday, 12:45-1:45 p.m.
10. Visiting Professors Programs

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
1st—Dept. of Medicine
2nd—Dept. of Surgery
3rd—Dept. of OB/GYN
4th—Dept. of Pediatrics
5th—Elective
2. Tumor Bd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.

2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
 3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
 4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
 5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
 6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
 7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
 8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
- Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

- Jan. 2, 7, 1981 Western Pharmacology Soc. Annual Mtg., Dept. of Pharmacology, Univ. of HI. 1960 E. West Rd., Honolulu 96822.
- Jan. 10, 17, 1981 Perinatal Med. U of So. CA Schl of Med, 2025 Zonal Ave. LA, CA. Held at Royal Lahaina Htl, Maui. 4 days, 24 hrs.
- Jan. 11, 17, 1981 "Recent Advances in Surgical Pathology." Spons: U of Chgo Schl of Med. & International Cntr. for Hlth Ed. Contact: Robt Schmidt, M.D., International Cntr for Hlth Ed., P.O. Box 3109, Lihue, Kauai, HI 96766, (808) 245-2121. Held at Kauai Surf, 25 hrs. Cat. I.
- Jan. 12-14, 1981 Practical Perinatology-Pediatric Pstgrad. Course. U of HI. Held at Honolulu. 12 hrs. Cat. I. For further info contact: Wilma Schiner, 1319 Punahou St., Honolulu 96826, (808) 947-8511.
- Jan. 15, 22, 1981 Med. Staff of Iowa Lutheran Hosp-Postgrad Conf. Iowa Lutheran Hosp, De Halder, Exec Sectry, U at Penn Ave., Des Moines, IA 50316. Held: Kauai Surf Htl, Kauai. 6 days, 24 hrs.
- Jan. 18, 25, 1981 Sixth Ann Hawaii Hosp Med Staff Conf., Estes Park Inst. w/Queen's Med Cntr. Kauai Surf Htl, Kauai. Estes Park Inst., Box 400, Englewood, CO 80151. 5 days, 32 hrs.
- Jan. 24, 31, 1981 Internatl Diagnostic Radiology. U of CA, Extended Prgms in Med. Ed., Dept. of Radiology, Rm M 396, 3rd & Parnassus Ave., San Fran, CA 94143. Held on island of Hawaii. 5 days, 40 hrs.
- Jan. 26, 29, 1981 Adv. Sems. for Phys. Administrators & Trustees. Estes Park Inst., Box 400, Englewood, CO 80151. Held: King Kamehameha Htl., Kailua-Kona, HI. 3 days, 15 hrs.
- Feb. 1, 8, 1981 Clinical Allergy. J. A. Burns Schl of Med., U of H. Honolulu, HI. Held: Hyatt Regency, Maui. Contact: Dee Chang, (808) 947-8573 or 948-7457.
- Feb. 2, 8, 1981 "Instrumentation in the Clinical Lab.: An International Perspective." Sponsor: World Assoc. of Societies of Pathology & International Cntr. for Hlth. Ed. Contact: Robt. Schmidt, M.D., International Cntr. for Hlth Ed, P.O. Box 3109, Lihue, Kauai, HI 96766, (808) 245-2121. Held: Kauai Surf Htl. Kauai. 25 hrs. Cat. I.
- Feb. 4, 6, 1981 Office Dermatology for the Primary Care Physician. J. A. Burns Schl of Med., 1960 E-West Road, Honolulu, 96822. Co-sponsor: Hi Chapt. AAFP. Held at Kahala Hilton Htl, Honolulu. 3 days, 12 hrs.
- Feb. 6, 7, 1981 Third Symposium on Diabetes in Asia and Oceania. J. A. Burns Schl of Med. Honolulu. Held: Kobe Univ. School of Medicine, Honolulu.
- Feb. 15, 21, 1981 Symp on Preleukemic & Acute Nonlymphocytic Leukemia. J. A. Burns Schl of Med. Held: Hyatt Regency, Honolulu. 5 days, 25 hrs.
- Feb. 15, 21, 1981 "Infectious Diseases: Recent Advances in Treatment & Prevention." Spons: American Bd. of Med. Microbiology; Nat'l. Regis. of Microbiologists, & International Cntr. for

Hlth Ed. Contact: Robert Schmidt, M.D., International Cntr. for Hlth Ed, P.O. Box 3109, Lihue, Kauai, HI. Held: Kauai Surf Htl. 25 hrs. Cat. I.

- Feb. 21, 1981 "What's Right with the World"—a Wellness Seminar. Spons: HMA & HCMS Auxiliary. 8am-3pm. 5½ hrs. Cat. I. Held: Ala Moana Htl., Hibiscus Ballroom, Honolulu. Contact: Susan Spangler (808) 734-2925.
- Feb. 21, 28, 1981 Practical Neurology for Primary Phys. U of Wash. Schl. of Med., CME SC-50, Seattle 98195. Held: Kona Surf, Kona, HI.
- Feb. 21, 28, 1981 Metabolism & Endocrinology. U of Wash CME SC-50, Seattle 98195. Co-sponsor-Wash State Med. Assn. Held: Kona Surf, Kona, HI. 7 days, 49 hrs.
- Feb. 23, 25, 1981 Postgraduate Course in Vascular Surgery. Am Col of Surgeons/co-sponsor J. A. Burns Schl of Med., U of H. Held at Hawaiian Regent Hotel, Honolulu.
- Mar. 2-6, 1981 Surgical Diagnosis & Therapy Phil Thorek Pstgrad. Courses, 850 Irving Park, Chicago, IL 60613. Hels-Kauai 20 hrs. Cat. I
- Mar. 16-20, 1981 Sports Medicine Course-U of HI J. A. Burns Schl of Med. Box CE-CCECS, 2530 Dole St. Honolulu 96822. Cospons: AmAcadFam-Phys. Held: Waikiki. 18 hrs. Cat. I.
- Apr. 4, 12, 1981 Calif. Soc. of Anesthesiologists. Dr. Norman R. Catron, Exec. Dir., 100 S. Ellsworth Ave., San Mateo, CA 94401. Held: Kauai Surf, Kauai, HI.
- Apr. 4, 11, 1981 Current Concepts in OB/BYU. U of Wash CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Kona Surf, Kona, HI. 49 hrs. Cat. I.
- Apr. 10, 17, 1981 Med. Imaging in Kauai. Am. Coll of Med Imaging, Box 27188, L.A., CA 90027. Held: Kauai Surf Htl., Kauai, HI. 24 hrs. Cat. I.
- Apr. 11, 18, 1981 Drug Therapy & Infectious Diseases. U of Wash., CME SC-50, Seattle, 98195. Held: Kona, HI. 49 hrs. Cat. I.
- Apr. 11, 18, 1981 Office Management of Chronic Pain. U of Wash, CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Wailea Beach Htl., Maui, HI. 49 hrs. Cat. I.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



"WE BETTER TAKE HIM COMPLETELY OFF PABULUM!"



Friday, November 7, 1980 HMA CONFERENCE ROOM

PRESENT:

Drs. Winn, Catts, Hindle, Bell, Chinn, Kam, Don, Lumeng, Bruce, Cahill, Simmons, Wagle, Fu, Newman, Goto, Chang, Dang, Kunimoto, Uemura, and Mrs. May Kim. HMA Staff present were: Messrs. Won, Jones, and Leineweber; Mmes. Kendro, Chang, Wong, and Young.

CALL TO ORDER:

The meeting was called to order by President Winn at 6:00 p.m.

MINUTES:

The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:

The Council reviewed the report of the Secretary as of October 31, 1981 which indicated that HMA membership totaled 919 as compared with a total of 911 in October 1979.

REPORT OF THE TREASURER:

The September 1980 financial statement was reviewed in detail and filed subject to audit. The Council approved a recommendation to give HMA employees an annual bonus of 2% of the annual gross salary, which has been the custom in the past.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Annual Meeting: Convention Chairman, Dr. Herbert Uemura, provided Council with a follow-up report on the 1980 Annual Scientific Meeting, October 13-17, 1980. Since this year's program was not a joint effort with the AMA, the Committee had anticipated a deficit of \$15-20,000. Dr. Uemura reported, however, that the 1980 Annual Meeting will have a deficit of just under \$1,500. Disappointment was expressed regarding the small number of HMA members who attended the scientific sessions. The Scientific Program Committee will be evaluating this year's program, with a view toward formulating recommendations for future Annual Meetings, particularly for those years in which the scientific sessions are not held in conjunction with the AMA's Regional CME Meeting. A motion to

delete CME courses during the 1982 Annual Meeting was tabled until such time that the Committee presents its recommendations.

B. 1981 Committee Structure: Distributed for Council's information was the 1981 committee/commission structure.

C. Elections: Since it is customary for the Council to annually elect members of the Finance Committee, Bureau of Research and Planning, and Building Committee, the Council reviewed the slate of nominations presented by the President and elected the following, subject to Dr. Bernard Fong's acceptance of the nominations:

Finance Committee

Albert Chun-Hoon, MD
Bernard Fong, MD
Doris Jasinski, MD
Elmer Johnson, MD
Ronald Peroff, MD

Bureau of Research & Planning

Calvin Sia, MD (1983), Chairman
John Wellington, MD (1983)
Douglas B. Bell, II, MD (1983)
Calvin C. M. Kam, MD (1983)
Walter Quisenberry, MD (1983)

*Building Committee**

Elmer Johnson, MD (5-year term, 1985), Chairman
Sydney Fujita, MD (4-year term, 1984)
Bernard Fong, MD (3-year term, 1983)
Walter W. Y. Chang, MD (2-year term, 1982)
Samuel Yee, MD (1-year term, 1981)

*1980 HMA House of Delegates changed Building Committee to a 5-member, staggered term committee, to be appointed by the President with Council approval.

The Council also confirmed the appointment of Dr. Drake Will as Cancer Commission Chairman for 1981. Council agreed to postpone the appointment of the HMA representative to the Commission.

D. Eye Safety Resolution: Dr. Allan Kunimoto, President of the Hawaii Ophthalmological Society, discussed the intent of the proposed eye safety resolution (No. 6) which was submitted to the 1980 House of Delegates by Dr. John Corboy and subsequently referred by the House to Council for further study.

ACTION:

It was moved, seconded, and passed to ADOPT Resolution No. 6, as amended.

RESOLUTION NO. 6

Re: *EYE SAFETY*

WHEREAS, recent nationwide studies of cases of unnecessary severe eye damage reveals that one of the most frequent causes of said damage is the failure of non-medical practitioners to suspect eye disease and properly advise the patient of the need for evaluation or treatment by a medical doctor; and

WHEREAS, such cases have resulted in needless blindness and suffering throughout the nation, including Hawaii; and

WHEREAS, the individual patient has the right to know when signs observed by non-medical practitioners or symptoms reported to him indicate the need for consultation with, or treatment by, a medical doctor; and

WHEREAS, there is ample precedent for government requiring health safety standards be met and warnings be issued regarding products or services which may jeopardize the public health; and

WHEREAS, eye examinations are being provided to the patients of medical doctors in Hawaii by non-medical practitioners who may fail to refer possible evidence of eye disease to medical doctors; and

WHEREAS, medical ethics demand that Doctors of Medicine provide their expertise and advice to government on issues affecting the public and health; and

WHEREAS, the organization recognizes the precious gift of eyesight as the most valuable of the sense;

RESOLVED, that the members of the Hawaii Medical Association urge all State Legislators to pass a law requiring that each patient having an eye examination by a non-medical practitioner be advised to seek medical evaluation or treatment by a medical doctor when certain signs or symptoms, indicating the possibility of disease, are reported by the patient or observed by the examiner.

JOHN M. CORBOY, M.D.

E. EMS: Dr. William Dang reported that the HMA-SDOH contract for Fiscal Year 1981 was executed shortly after HMA-EMS received approval for status as sole source provider on September 29, 1980. Council briefly discussed efforts to improve funding arrangements. Two payments from SDOH have been received, and a third payment is expected in a few

days. Dr. Dang also reported that contract negotiations between the HMA and SDOH for neighbor island First Responder and EMT training is expected to commence in the near future. The EMS Board recommended that HMA support the Hawaii Heart Association's goal of training 20% of the general public in CPR (through CPR Center).

ACTION:

It was moved, seconded, and passed that HMA endorse the concept of having the Hawaii Heart Association train 20% of the general public in CPR.

F. Jail Health Project: Dr. Walter Chang and Mrs. Becky Kendro briefed the Council on the AMA Jail Health meeting they attended in Chicago, October 24-26, 1980. Since the LEAA will discontinue funding the program after May 1981, the AMA will be re-evaluating its future role in the jail health program. Dr. Chang reported that the committee has completed its site visit of the Oahu Prison and will be working on a program for implementation.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Calvin Kam reported that the Society's next general membership meeting is slated for November 3, with Mr. Robert Nickel of HMSA as the guest speaker on the subject of health maintenance organizations. The HCMS Annual Banquet Meeting and sports tournaments will be held on December 7 at the HICC.

Dr. Kam pointed out that the House of Delegates had approved the Reference Committee on Finance's recommendation to conduct a survey to determine the appropriateness of the annual payment amount by HCMS under the HCMS/HMA agreement for services. A suggestion was made that neighbor island representatives be included on the committee when the study is conducted, and that the study include a review of Board of Governors and HCMS committees' minutes.

ACTION:

It was moved, seconded, and passed to refer the matter of the HCMS/HMA agreement to the Executive Committee for implementation of the House's action.

B. Maui: Dr. Andrew Don reported that the Society had guest speakers from a HMO/IPA at its last membership meeting. This month MCMS will be holding its annual election, with a guest speaker from the State Disability Branch; and in December the Society's Annual Christmas dinner at the Hyatt Hotel. Dr. Don reported that the Society's 1981 dues have been increased by \$22, and the MCMS Recruitment Committee is exploring avenues for gaining new members. The Society has received verbal approval from the CCPH for a Maui County subcontract for an oncology program.

OTHER BUSINESS:

A. Aces and Deuces: Dr. Winn recommended that Council consider maintaining HMA's membership in the Aces and Deuces Society.

ACTION:

It was moved, seconded, and passed that HMA maintain its membership in the Aces and Deuces Society at \$75.

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be taken care of.*

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B. Dues Reduction Program: Mr. Jon Won pointed out that the 1980 House of Delegates had passed Bylaws amendment 9.022 in an effort to implement action by the 1978 House to give a 50% reduction in dues to physicians in their first year of practice after residency. The amendment, as passed, states that the reduction may be granted at the discretion of Council. Mr. Won requested that Council adopt a policy for 1981.

ACTION:

It was moved, seconded, and passed that HMA follow the recommendations of the county societies.

ACTION:

A motion to refer this matter to the Bylaws Committee failed to pass.

ACTION:

It was moved, seconded, and passed that Section 9.022 of the Bylaws be made consistent with AMA policy.

C. Hawaii Health Institute: Presented to Council was an informational handout on the concept of a Hawaii Health Institute.

ACTION:

It was moved, seconded, and passed to retain this concept as a committee of the Association.

D. Pacific PSRO: Mr. Jon Won reported that Pacific PSRO had moved its offices from the HMA Building at the end of September. With regard to the employee's pension plan, it was tentatively agreed that HMA's pension plan will fully vest PacPSRO employees for their years of service.

E. Auxiliary: Mrs. May Kim reported that the Maui Auxiliary held its recent Board meeting with the Dental Society. Mrs. Kim expressed the Auxiliary's concern regarding HMA's future funding of Auxiliary activities as the House of Delegates had recommended that Auxiliary membership be on a voluntary basis rather than on an automatic basis.

ACTION:

It was moved, seconded, and passed to refer this matter to the Executive Committee.

F. Parliamentary Course: Dr. Winn announced that Dr. Richard Ando, registered parliamentarian, has offered to conduct a 2-hour course on parliamentary procedures. Council members were asked to consider this offer and to think about the possibility of HMA having a speaker of the House.

G. Union: The President reported that HMA representatives will meet with Union representatives on November 10. The Physicians Union will hold a meeting on November 13 to discuss the formation and activities of the union.

H. Hiroshima Board of Directors: A suggestion was made that HMA request the AMA Board of Trustees to extend an invitation to the Board of Directors of the Hiroshima Prefectural Medical Association to attend the AMA Interim Meeting in 1981.

ACTION:

It was moved, seconded, and passed that HMA ask the AMA Board of Trustees through Trustee Dr. George Mills, to invite the Hiroshima Board of Directors to attend the AMA 1981 Interim Meeting.

I. Negotiations Seminar: The President announced that HMA will sponsor a negotiations seminar on January 24-25, 1981. Speakers from the AMA's De-

partment of Negotiations will conduct the 1½ day seminar, which has been accredited by the AMA for approximately 13 hours of Category 1 CME credit. Registration in the seminar is \$100; and officers, committee chairmen, and commissioners are invited to participate.

MISCELLANEOUS BUSINESS:

A. Meeting Schedule: The Executive Committee will meet on December 4 at 12:30 p.m. and commissioners may attend to discuss Council agenda items. The next HMA Council meeting has been postponed until December 12, at 5:30 p.m. in that the officers will be attending the AMA's Interim Session during the week of December 5.

ADJOURNMENT:

The meeting was adjourned at 9:10 p.m.

Our "Angels"

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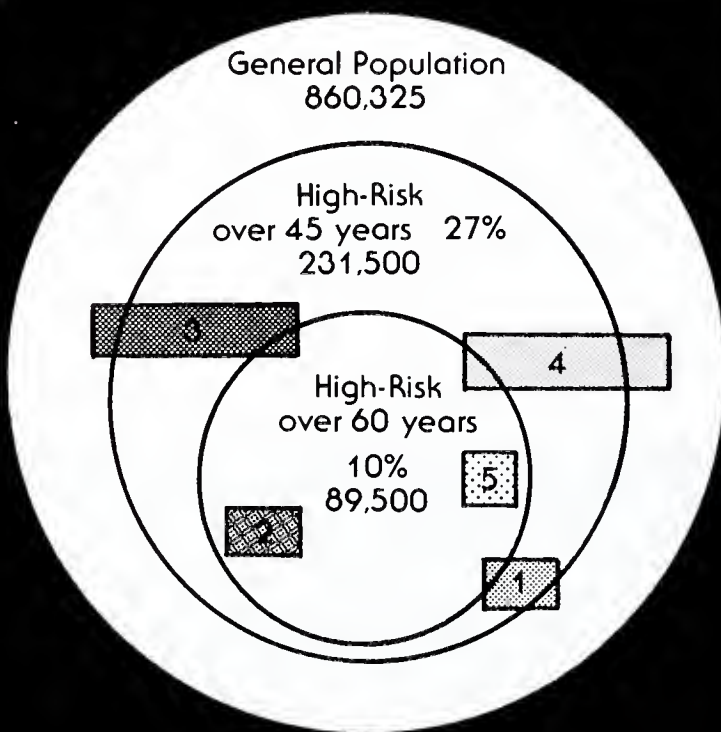
G.I. CANCER PROGRAMS

One major focus of the Community Cancer Program of Hawaii is high-risk target groups for early detection of Gastro/Intestinal Cancer. 10% of Hawaii's population is over 60 years of age; 27% of the population is over 45 years of age and those over 45 years are considered or relatively high-risk for most cancers.

Gastro/Intestinal cancer programs are directed toward those who are at high risk with special emphasis on ethnicity, age, lifestyle and familial patterns, to detect cancers at the earliest possible stage of development.

The programs focused on senior citizens will utilize a network of existing community agencies for information, education, direct service referrals and follow-up procedures. A plan to evaluate the effectiveness of the programs is currently being developed.

The following chart indicates the particular programs which cut across the target high risk groups:



THE PROGRAMS INCLUDE:

- 1 Woikiki Health Center Multi-Site, Multi-Intervention Demonstration Program for Senior Citizens (aged 50 years and above).
- 2 Cancer education as a component of the St. Francis Hospital/Health Screening for Senior Citizens (aged 60 years and above).
- 3 Presently employed and retired Sugar Workers and their spouses—assisting ILWU/Sugar Industry in organization, program development, implementation and evolution of cancer education programs and in administration of high-risk questionnaire (age 45 years and above).
- 4 Monogement Outlines; Public and Professional Education; Radio and TV Spots; Posters and Brochures.
- 5 In-Service Training for those working with high-risk groups, such as: (a) senior companions, (b) respite care for the elderly, (c) outreach workers and (d) senior citizen volunteers.

For further information call 548-8422 or write
Director, Community Cancer Program of Hawaii,
1236 Louhola Street, Honolulu, HI 96813.



Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

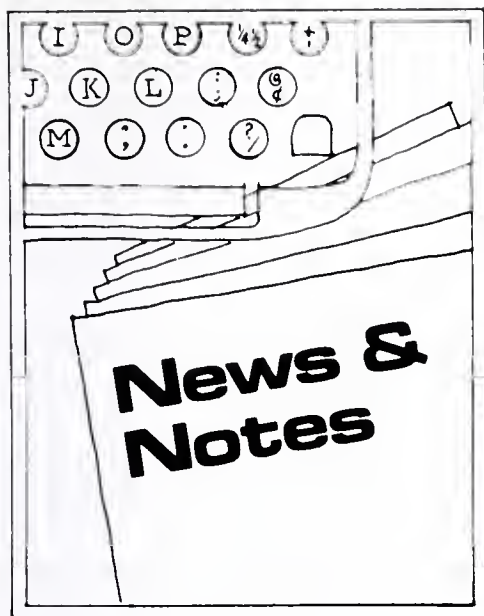
Happy New Year!

We welcome a new member this month, **John Aoki**, a Tripler family physician, who has joined our chapter. He already holds membership in AAFP and the Uniformed Services chapter.

Congratulations to **Varian Sloan** who becomes a Life member. To list just a few of his many accomplishments: Varian is a charter member of AAFP (1947), was president of our chapter in 1959 and served on the AAFP Board of Directors from 1962 to 1965. In 1965 he received HMA's Robins Award as Physician of the Year . . . At the HMA annual meeting **Fred Dodge** moderated a panel on Preventive Medicine and also gave a presentation based on his work with prospective medicine techniques. This was well received and widely covered by the local press.

We continue to receive inquiries as to why AMA Cat. I credit is not automatically acceptable for "P" credit by the Academy. The main criterion for AAFP approval of a program is its suitability for the family physician. To assure this suitability, there must be participation by family physicians in program planning, followed by state and national approval. Often program directors do not seek such participation. This subject was debated again at the recent Congress of Delegates and the requirement of FP input was reaffirmed. We urge members to check with program directors prior to registration as to whether "P" credit is given. Remember, Cat. I does *not* necessarily equal "P" credit.

Six hours "P" credit *will* be given for the HAFP seminar held in conjunction with the annual meeting on February 14 at the Ilikai. It offers a variety of subjects and speakers, both from Hawaii and the mainland. Please make reservations early for the seminar as well as the annual meeting and dinner held that same evening also at the Ilikai. **Lincoln Luke** and his committee have nominated the following slate for election: President Elect: **Robert Todd** . . . Secretary: **Lily Ning** . . . Treasurer: **Don Farrell** . . . Delegates: **Tom Cahill** and **Don Farrell** . . . Alternate Delegates: **Lincoln Luke** and **Jim Tsuji** . . . Councillor thru 1983: **John Aoki**, **Pat Walsh** and **Nate Wong** . . . Councillor thru 1981 (to serve out term of **Don Newman**): **Arch Wigle**. **Jim Tsuji** becomes President to succeed **Pat Dietrich**. Nominations have not been closed and will be accepted from the floor at the annual meeting. See you there!



HENRY N. YOKOYAMA, M.D.

Aphorisms

"Everyone wants to live long, but no one wants to age" (Gerontologist Otto Neurath). "There is something frustrating about science. One gets such wholesale returns of conjecture out of a trilling investment of fact." (Mark Twain's remark applies to gerontology says Otto Neurath . . .)

Professional Moves

We haven't made an exact count, but judging from the volume of ads relating to physician movements in this Zodiac Year of the Monkey, we judge that more physicians have opened new offices or relocated this year than ever before in our history . . . We hereby dub this the "Year of the Doctor with Itching Feet" . . .

In November, physicians continued to pour into the St. Francis Medical Office Bldg.: Internist **Elsie Blossom Wang** relocated to Suite 305; internist **Gladys Fryer** opened in Suite 400; ophthalmologist **Worldster Lee** relocated to Suite 106; and urologist **Herbert Chinn** relocated to Suite 205.

New internist in town, **Richard Min** joined **Thomas Min** at Queen Physician Office Bldg. and **Russel Hicks** (specializing in adolescent medicine and internal medicine) and **Raquel Hicks** (pediatrician and adolescent rheumatologist) opened their office in the Kapiolani-Children's Medical Center . . . Ophthalmologist **James Johnston** reopened his Kailua office at 45 Aulike St. Suite 47 and psychiatrist **Mark Bernstein** joined the Straub Clinic & Hospital, Inc. On the Big Island, FP **Kelvin De Ginder** opened at 1342 Kilauea Avenue . . .

We were flattered when Rose, our HMA secretary who handles newspaper ads for physicians, was asked by a new physician in town if he could announce in this column that he was opening his office in January next year . . . We wondered "Why not?" but then we declined the honor because we have always compiled our information from post publication newspaper ads . . .

Hors de Combat

An out-of-court settlement will provide \$1.25 million to an 8-year-old Honolulu girl who was brain damaged at birth . . . The city will pay \$800,000 while the hospital and two doctors involved will pay the \$450,000 balance. (Ed. It just isn't right! But oh, heck!)

Ronald Reagan's health advisers, headed by William Walsh, who directed Project Hope, are urging a national catastrophic health insurance system which would insure everyone against illnesses costing more than a fixed amount. During his campaign, Reagan had advocated catastrophic coverage instead of comprehensive national health insurance. A health care study financed by Hoffman-La Roche has concluded that only 29.4% of the population has adequate catastrophic insurance. Sen. Ed Kennedy, however, contends

that catastrophic insurance by itself is inadequate because millions can't afford to pay the first few thousand dollars of medical bills . . .

Kona police arrested an 18-year-old Captain Cook girl for breaking into **Elizabeth Marshall's** office and taking a medical bag with instruments and drugs valued at \$500 . . .

Perhaps we are akin to the proverbial ostrich with its head buried in sand, or to those oriental monkeys who neither see, hear, nor talk . . . But we refuse to believe all the ridiculous charges about our friends and fellow physicians being indicted in Abscam type frame ups . . . esp **Gail Li**, **Walter Yokoyama**, **Ethel Oda**, **Edwin Adams**, etc, etc . . . These are truly very trying times for us all . . .

We read with interest what Philip Sandblom, world renowned surgeon and guest lecturer, had to say about the lives of artists and their diseases . . . Picasso became "pornographic" when he became ill, D. H. Lawrence exaggerated the importance of sex in his "Lady Chatterley's Lover" because of his own weakness from tuberculosis, and Moliere, who also had tuberculosis and was badly treated, wrote four plays which made fun of doctors . . . Sandblom has also written about the responsibility that society has to surgeons. He contends that when society finds that unique combination of humanistic qualities, intelligence, and manual dexterity required, then it should encourage those persons by making surgery a stimulating and economically rewarding career . . . "In most callings, you can be half good, but there is no such thing in surgery. A half-good surgeon is a tragedy." Relating to national health care, Philip says, "I don't agree that doctors should all get terribly rich, but with such responsibility and such hard work, they should be able to enjoy the prosperous things in life like any successful businessman or administrator."

Medicare Review Meeting (At Duke's Inn)

Problem: Whether or not penile prosthesis in Medicare age patients should be regarded as cosmetic or not . . . Should we not have criteria for those who qualify for such surgery? Question: Should sleep EEG be paid more than awake EEG? And why? Problem: A surgeon charged separately for gastrectomy and for the gastrojejunostomy. Question: If paid only for the gastrectomy, would he have stopped there and left the gastrojejunostomy undone? Problem: The surgeon doing a breast biopsy and a modified radical when the frozen section shows malignancy does not get paid for the biopsy. On the other hand, the surgeon who does the biopsy, closes up, and then proceeds with a radical breast after permanent sections show malignancy is paid for both the biopsy and the surgical procedure . . .

Elected, Honored & Appointed

We congratulate **Sharon Bintliff**, our professor of pediatrics at John Burns School of Medicine and director of the Birth Defects Center at Kapiolani-Children's Medical Center, for being one of five women chosen for outstanding achievement by the YWCA of Oahu . . . Sharon who won the award in the professional category, is the director of the University Affiliated Facilities Project for children with developmental disabilities, and has served as medical director for the Waimano State Home and was chairman of the governor's Committee on Children and Youth. (Intellectual and administrative achievements . . . Bah! . . . We prefer to remember her other accomplishments eg, Junior golf champ in Texas, tournament class tennis player, surfing enthusiast, boogie boarder, canoe paddler, jogger, runner . . . etc, etc . . .)

Hail to the PSRO! New board members are **Robert Flair**, **Robert Bell**, **Jared Sugihara**, **Robert Simmons**, **Richard Lundborg** and **Melvyn Kaneshiro** . . . Durable **Winfred Lee** was reelected president, **James Stewart** is VP, **William Sage**, secretary and **Robert Wilcox**, treasurer. (Ed. As a former PSRO board member we appreciate the time and effort these board members and officers put in to prevent Fed intervention . . . esp our indomitable Winnie . . .)

The Habilitat elected **Victoria Gamer**, **Sidney Heilveil** and **Glenn Stahl** directors . . . The American Cancer Society, Hawaii Division elected **Carl Boyer Jr.** new president and **John Keenan** one of its vice presidents . . . Hospice Hawaii, Inc. elected **Robert Nathanson** president . . . Castle Hospital medical staff elected **Robert Nemechek** chief of staff . . . Mayor-elect Eileen Anderson has wisely decided to keep **Charles Odom Jr.**, former faculty member of the UH Med School, on as city medical examiner . . . The Association of Hawaiian Civic Clubs has elected immediate past president, **George Mills**, president emeritus (a special honorary life long position) . . . The Kaiser Foundation Hospital medical staff elected **Adela Sanidad** president, **Gordon Ing** VP and **Michael Chaffin**, secretary . . . The Society for Adolescent Medicine installed our UH Med School Pediatric Department chairman **Sherrel Hammar** president at the association's annual meeting in Detroit . . . The American Board of Family Practice named **Samuel Gingram** of Kamuela diplomate . . . **Ernest Bade** of Hilo and **Michael Padwick** of Pahala were recertified as diplomates . . . **Mark Wentworth** of Waimea was also recertified as a diplomate . . . The American Heart Association Emergency Cardiac Care Subcommittee reappointed **William Montgomery** who is chief of anesthesiology at Straub Clinic . . . The Hawaii Medical Library's board of governors elected new members, **Charles Judd Jr.**, **Ernest Sheerer**, **Clifford Strachley** and **John Chalmers** . . .

Life in These Parts

George Ewing and **Peter Larm** had attended the meeting of the American Association for Clinical Immunology and Allergy and were both staying at the Las Vegas MGM Hotel when the fire broke out. Lucky for George, he had turned on the television and learned that his hotel was on fire, otherwise he would've still been in bed . . . George managed to get out

with only some clothes and his brief case . . . Peter was up early for a 9 a.m. flight and was dressed and packed at 7:15 . . . All of a sudden his room turned dark and he said, "Oh my god! What's going on?" He saw smoke billowing past his window. He grabbed his bags and after trying the stairwells filled with hot gas and smoke, he finally found a clear fire escape. Peter recalled the movie, "The Towering Inferno," "Sure enough, that's what happened . . . It was an inferno alright."

Allan Young, another allergist had also attended the same meeting. In the recent HCMS golf tournament held at HICC he won the B flight 1st prize and then a door prize to boot . . . This prompted Allan to get up on the podium to announce how lucky he has been of late . . . "Only two weeks ago, I was at an allergy meeting in the MGM hotel and had left the day before the fire . . ." Allan is convinced that there is an Almighty up above looking out for him . . .

Excerpt from Don Chapman's column: "A mention of his book in 'Dear Abby' should mean lots of sales for Honolulu's **Dr. John McDermott Jr.** and his 'Raising Caine (And Abel, Too)—The Parent's Book of Sibling Rivalry.' Parents magazine will excerpt sections of his book . . ."

Earlier this year, a group of physicians announced that 100 local physicians were interested in forming a union. In November, after a dinner meeting at Yong Sing Restaurant and hearing Sanford Marcus of San Francisco, president of the American Union of Physicians and Surgeons discuss the operation and benefits of his 28,000 member national union, 200 Island physicians decided to form a union of Hawaii physicians. They named neurosurgeon **Maurice Nicholson** chairman and ophthalmologist **John Corboy**, internist **Raymond DeHay**, anesthesiologist **Bert Gilling** and OB Gyn man **John Ohtani** members of a steering committee . . .

Excerpt from Dave Donnelly's Hawaii: "Though Howard Hughes is dead and the mystery cruise of his Glomar Explorer research ship to raise a sunken Russian sub is almost forgotten, patients of **Dr. Gary Globler**, the Queen's gastroenterologist and proctologist, still call him 'The Globler Explorer.'"

Tom Kobara, (Life Member, Hawaii Rifle Association) wrote: "Special interest groups are mouthing off and saying that 'people kill people, not—' Anyone who has been reading the papers recently should know that knives kill people . . . Therefore I beseech our legislators to work toward registration of all knives over 2½ inches in length, blunt butter knives for home use excepted. My intent is not to burden law abiding teppan-yaki chefs but to cut down on knife-related killings."

DASH (The Drug Addiction Services of Hawaii) a private, but state funded heroin addiction treatment program is called a bust . . . Between Jan. 1976 and March 1977, 255 heroin addicts applied for treatment . . . There was a 41% dropout before detox was started and a 32% dropout after finishing detox . . . Of the 32% who stayed for the two weeks of detox, ½ showed signs of continued drug abuse during the detox period . . . The majority of those who stayed with detox soon dropped out of treatment . . . Caucasians, mostly new comers to Hawaii represented 62%. Mixed ancestry represented 10.2%, Hawaiian and part Hawaiian, 9.8% and Japanese 6.7%.

Excerpts from "parent's hotline" headlined "Vegetarian diet termed adequate for growing child": "If a vegetarian diet is carefully planned and your child continues to remain in the ideal weight range for his height, he should be getting all the proper nutrients for growth," says **Dr. Charles Yamashiro**, a vegetarian himself who with wife, Naomi, has raised four children on a meatless diet . . . In fact, pediatrician **Dr. Wayne McKinny** says, "There is all kinds of evidence we are just eating too damn much meat. We need to eat more complex carbohydrates such as grains and cereal." McKinny says he constantly preaches to parents to give their children a wide variety of fruits, vegetables, cereals, grains and precious little animal fat . . . ■

Happy New Year



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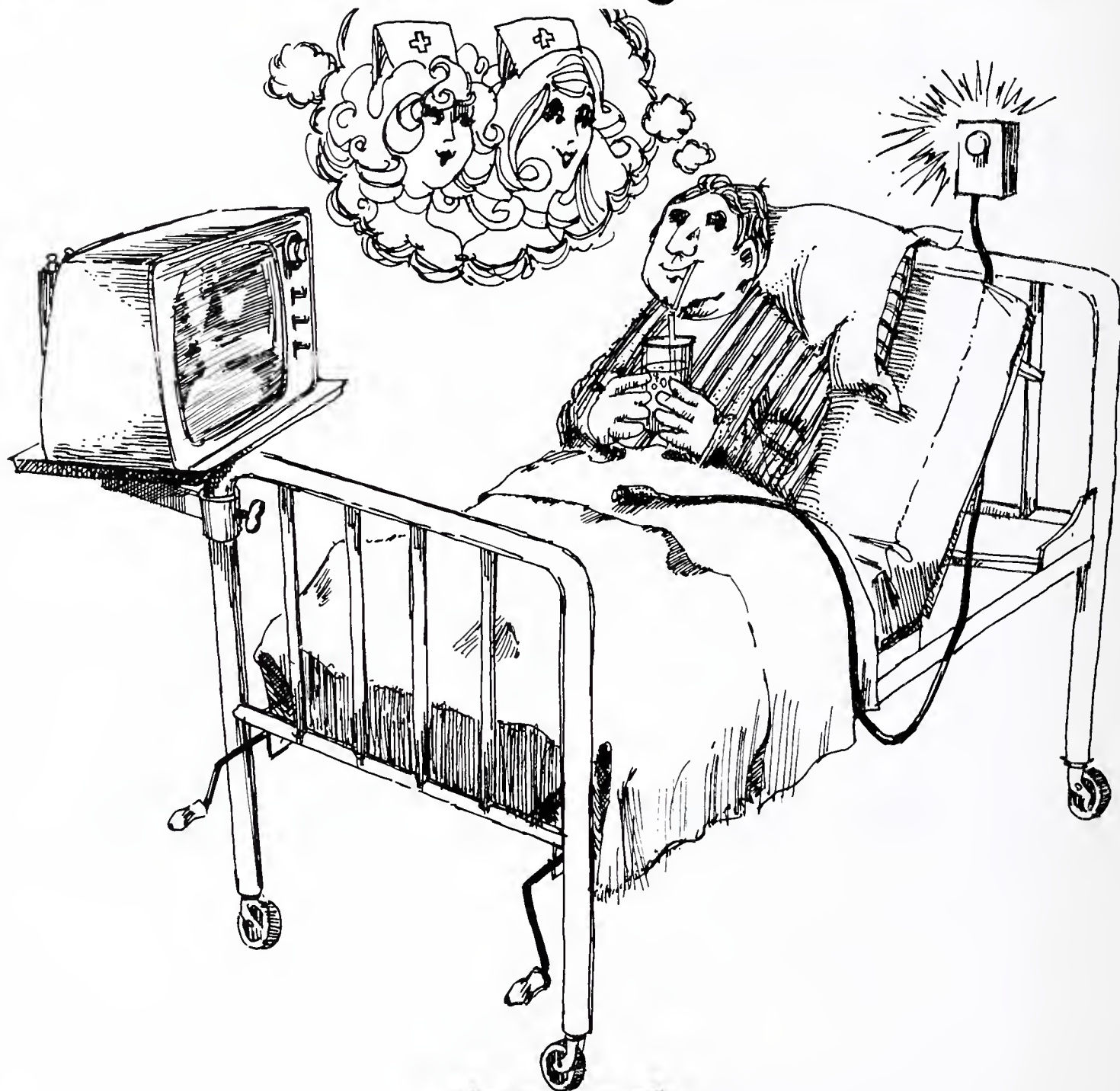
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